

MONTANA LEGISLATIVE HISTORY

Chapter 532 19 91

Bill H 620 S _____

Original bill & history a c

H. Committee on <u>Human ^{Services} Resources</u>	S. Committee on <u>Public Health, Welfare</u>
Hearing Date(s) <u>2/20</u> <u>x</u> c	Hearing Date(s) <u>3/18</u> <u>x</u> c <u>501.1</u>
_____ c	<u>3/20</u> <u>x</u> c
_____ c	<u>3/21</u> <u>x</u> c
_____ c	_____ c
Date Out _____ c	

Did this bill originate in an interim committee? _____ Yes x No

Committee _____

Report _____

HB 620 INTRODUCED BY SQUIRES, ET AL

REGULATE THE PRACTICE OF RESPIRATORY CARE;
ESTABLISH A RESPIRATORY CARE BOARD

2/05	INTRODUCED		
2/05	REFERRED TO HUMAN SERVICES & AGING		
2/06	FIRST READING		
2/06	FISCAL NOTE REQUESTED		
2/11	FISCAL NOTE RECEIVED		
2/11	FISCAL NOTE PRINTED		
2/20	HEARING		
2/21	COMMITTEE REPORT—BILL PASSED		
2/22	PLACED ON CONSENT CALENDAR		
2/27	3RD READING PASSED	94	6
	TRANSMITTED TO SENATE		
2/27	REFERRED TO PUBLIC HEALTH, WELFARE & SAFETY		
3/04	FIRST READING		
3/18	HEARING		
3/21	COMMITTEE REPORT—BILL CONCURRED AS AMENDED		
3/22	2ND READING CONCURRED	32	12
3/23	3RD READING CONCURRED	37	10
	RETURNED TO HOUSE WITH AMENDMENTS		
4/09	2ND READING AMENDMENTS CONCURRED	94	2
4/10	3RD READING AMENDMENTS CONCURRED	95	4
4/17	SIGNED BY SPEAKER		
4/17	SIGNED BY PRESIDENT		
4/17	TRANSMITTED TO GOVERNOR		
4/22	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 532		

EFFECTIVE DATE: 04/22/91 - SECTIONS 3-5, 14-17

EFFECTIVE DATE: 10/01/91 - SECTIONS 1, 2, 6-13

HB 621 INTRODUCED BY SWYSGOOD

ALLOW BOARD OF PUBLIC EDUCATION TO PERMIT
USE OF FOUR-WHEEL DRIVE VEHICLES

2/05	INTRODUCED		
2/05	REFERRED TO EDUCATION & CULTURAL RESOURCES		
2/06	FIRST READING		
2/20	HEARING		
2/20	TABLED IN COMMITTEE		

HB 622 INTRODUCED BY SWYSGOOD

ELIMINATE AGRICULTURAL BUSINESS INCUBATOR PROGRAM

2/05	INTRODUCED		
2/05	REFERRED TO AGRICULTURE, LIVESTOCK & IRRIG.		
2/06	FIRST READING		
2/06	FISCAL NOTE REQUESTED		
2/09	FISCAL NOTE RECEIVED		
2/09	FISCAL NOTE PRINTED		
2/13	HEARING		
2/14	COMMITTEE REPORT—BILL PASSED		
2/16	2ND READING PASSED	95	2
2/19	3RD READING PASSED	98	1
	TRANSMITTED TO SENATE		
2/20	FIRST READING		
2/20	REFERRED TO AGRICULTURE, LIVESTOCK & IRRIG.		
3/06	HEARING		
3/07	COMMITTEE REPORT—BILL CONCURRED		
3/12	2ND READING CONCURRED	49	0
3/13	3RD READING CONCURRED	49	0

RETURNED TO HOUSE

HOUSE BILL NO. 620

INTRODUCED BY SQUIRES, WEEDING

IN THE HOUSE

FEBRUARY 5, 1991

INTRODUCED AND REFERRED TO COMMITTEE
ON HUMAN SERVICES & AGING.

FEBRUARY 6, 1991

FIRST READING.

FEBRUARY 21, 1991

COMMITTEE RECOMMEND BILL
DO PASS. REPORT ADOPTED.

FEBRUARY 22, 1991

PRINTING REPORT.

POSTED ON ALTERNATIVE CONSENT CALENDAR.

FEBRUARY 27, 1991

THIRD READING, PASSED.
AYES, 94; NOES, 6.

TRANSMITTED TO SENATE.

IN THE SENATE

MARCH 4, 1991

INTRODUCED AND REFERRED TO COMMITTEE
ON PUBLIC HEALTH, WELFARE, & SAFETY.

FIRST READING.

MARCH 21, 1991

COMMITTEE RECOMMEND BILL BE
CONCURRED IN AS AMENDED. REPORT
ADOPTED.

MARCH 22, 1991

SECOND READING, CONCURRED IN.

MARCH 23, 1991

THIRD READING, CONCURRED IN.
AYES, 37; NOES, 10.

RETURNED TO HOUSE WITH AMENDMENTS.

IN THE HOUSE

APRIL 9, 1991

RECEIVED FROM SENATE.

SECOND READING, AMENDMENTS
CONCURRED IN.

APRIL 10, 1991

THIRD READING, AMENDMENTS
CONCURRED IN.

SENT TO ENROLLING.

REPORTED CORRECTLY ENROLLED.

1 House BILL NO. 620
2 INTRODUCED BY James C. Cline
3
4 A BILL FOR AN ACT ENTITLED: "AN ACT REGULATING THE PRACTICE
5 OF RESPIRATORY CARE; ESTABLISHING A QUASI-JUDICIAL BOARD OF
6 RESPIRATORY CARE PRACTITIONERS WITH RULEMAKING AUTHORITY;
7 REQUIRING LICENSURE OR A TEMPORARY PERMIT FOR RESPIRATORY
8 CARE PRACTITIONERS; REQUIRING FEES FOR A TEMPORARY PERMIT
9 AND A LICENSE; PROVIDING THAT THE FEES ARE DEPOSITED TO THE
10 SPECIAL REVENUE FUND FOR THE BOARD'S USE; PROVIDING
11 PENALTIES; REQUIRING PRACTITIONERS TO REPORT CERTAIN CONDUCT
12 AND PROVIDING IMMUNITY FOR REPORTING; AND PROVIDING
13 EFFECTIVE DATES."

14
15 STATEMENT OF INTENT

16 A statement of intent is required for this bill because
17 [section 5] grants rulemaking authority to the board of
18 respiratory care practitioners.

19 (1) In outlining the powers and responsibilities of the
20 board of respiratory care practitioners, it is the intent of
21 [section 5] that the board have authority to adopt rules to
22 implement and enforce [sections 1, 2, and 4 through 13] and
23 specific authority to adopt rules regarding:

24 (a) license and temporary permit applications and
25 procedures necessary to receive and process those

1 applications;
2 (b) examinations and criteria for grading examinations;
3 (c) disciplinary standards for licensees and temporary
4 permitholders, including definitions of conduct for which
5 discipline may be appropriate;
6 (d) continuing education requirements;
7 (e) investigations of complaints;
8 (f) setting and modifying appropriate fees;
9 (g) a process for renewal of licenses and temporary
10 permits, including procedures for late renewal;
11 (h) waiver of license requirements as provided in
12 [section 7(2)]; and
13 (i) reciprocity conditions applicable to licensure.
14 (2) It is the intent of the legislature that the
15 governor have the authority to implement staggered terms for
16 board members during the appointment process.

17
18 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

19 NEW SECTION. Section 1. Findings -- purpose. The
20 legislature finds and declares that the practice of
21 respiratory care in the state affects the public health,
22 safety, and welfare. To protect the public from the
23 unqualified practice of respiratory care or unprofessional
24 conduct by qualified practitioners, respiratory care is
25 subject to regulation and control. The purpose of [sections

1, 2, and 4 through 13] is to regulate the practice of respiratory care. The legislature recognizes that the practice of respiratory care is a dynamic and changing art and science that is continually evolving to include new ideas and more sophisticated techniques in patient care.

NEW SECTION. Section 2. Definitions. As used in [sections 1, 2, and 4 through 13], the following definitions apply:

(1) "Board" means the board of respiratory care practitioners established in [section 3].

(2) "Qualified medical direction" means the direction of:

(a) a medical director of an inpatient or outpatient respiratory care service, a respiratory care department, or a home-care agency; or

(b) a licensed physician with a special interest and knowledge about the diagnosis and treatment of respiratory problems.

(3) (a) "Respiratory care" means the care provided by a member of the allied health profession responsible for the treatment, management, diagnostic testing, and control of patients with deficiencies and abnormalities associated with the cardiopulmonary system. The term includes but is not limited to:

(i) administration of pharmacological, diagnostic, and

therapeutic agents related to respiratory care procedures that are necessary to implement a treatment, disease prevention, pulmonary rehabilitative, or diagnostic regimen prescribed by a physician;

(ii) transcription and implementation of the written or verbal orders of a physician regarding the practice of respiratory care;

(iii) observation and monitoring of a patient's signs and symptoms, general behavior, and physical response to respiratory care treatment and diagnostic testing, including determination of abnormal characteristics;

(iv) implementation of respiratory care protocols pursuant to a prescription by a physician; and

(v) initiation of emergency procedures prescribed by board rules.

(b) Respiratory care is not limited to a hospital setting but must be performed pursuant to a physician's order and under qualified medical direction. The term includes inhalation and respiratory therapy.

(4) "Respiratory care practitioner" means a person who has the knowledge and skill necessary to administer respiratory care and who is licensed under the provisions of [sections 6 through 10].

(5) "Student respiratory care practitioner" means a person:

(a) enrolled in a respiratory care educational program recognized by the joint review committee for respiratory therapy education and the American medical association's committee on allied health education and accreditation, or their successors;

(b) permitted to provide respiratory care under clinical supervision; and

(c) identified as a student respiratory care practitioner or "SRCP".

NEW SECTION. Section 3. Board of respiratory care practitioners. (1) There is a board of respiratory care practitioners. The board consists of five members appointed by the governor. Each member must be a citizen of the United States and a resident of this state. The governor may request advice from the Montana society for respiratory care in making appointments to the board.

(2) The board consists of:

(a) three respiratory care practitioners, each of whom has engaged in the practice of respiratory care for a period of at least 3 years immediately preceding their appointment to the board. At least one of these members must have passed the registry examination for respiratory therapists administered by the national board for respiratory care and at least one of these members must have passed the entry-level examination for respiratory therapy technicians

administered by the national board for respiratory care.

(b) one physician licensed in Montana who has a special interest in the treatment of cardiopulmonary diseases; and

(c) one member of the public who is not a member of a health care profession.

(3) The board is a quasi-judicial board. Members are appointed, serve, are compensated, and are subject to removal as provided in 2-15-124.

(4) The board is allocated to the department of commerce for administrative purposes only as provided in 2-15-121.

NEW SECTION. Section 4. Board meetings -- procedure -- seal. (1) The board shall meet at least once a year and shall elect annually a president, vice president, and secretary-treasurer from its membership. The board may convene at the request of the president or at other times the board determines necessary to transact its business.

(2) The board shall adopt a seal by which the board may authenticate its documents.

NEW SECTION. Section 5. Board powers and duties. (1) The board shall:

(a) examine, license, grant temporary permits, and renew the licenses or permits of duly qualified applicants;

(b) establish examinations and passing scores for licensure under [section 7];

(c) adopt and implement rules for continuing education requirements to ensure the quality of respiratory care.

(2) The board may:

(a) adopt rules necessary to implement the provisions of [sections 1, 2 and 4 through 13]; and

(b) establish relicensing requirements and procedures that the board considers appropriate.

NEW SECTION. **Section 6.** License required -- exceptions -- respiratory care not the practice of medicine. (1) Except as otherwise provided in [sections 1, 2, and 4 through 13], a person may not practice respiratory care or represent himself to be a respiratory care practitioner unless he is licensed or granted a temporary permit under the provisions of [sections 6 through 9].

(2) [Sections 1, 2, and 4 through 13] do not prohibit:

(a) the practice of respiratory care that is an integral part of study by a student respiratory care practitioner;

(b) self-care by a patient or the gratuitous care by a friend or family member who does not hold himself out to be a respiratory care practitioner; or

(c) respiratory care rendered in the course of an emergency.

(3) Nothing in [sections 1, 2, and 4 through 13] is intended to limit, preclude, or interfere with the practice

of other persons and health care providers licensed by the appropriate agencies of the state of Montana.

(4) Nothing in [sections 1, 2, and 4 through 13] may be construed to permit the practice of medicine.

NEW SECTION. **Section 7.** Licensing requirements -- examination -- fees. (1) To be eligible for licensure by the board as a respiratory care practitioner, the applicant shall:

(a) submit to the board an application fee in an amount established by the board and a written application on a form provided by the board demonstrating that the applicant has completed:

(i) high school or the equivalent; and
(ii) a respiratory care educational program accredited or provisionally accredited by the American medical association's committee on allied health education and accreditation in collaboration with the joint review committee for respiratory therapy education or their successor organizations; and

(b) pass an examination prescribed by the board, unless the examination requirement is waived under subsection (2). The board may use the entry-level examination written by the national board for respiratory care or another examination that satisfies the standards of the national commission for health certifying agencies or the commission's equivalent.

(2) The board may issue a license to practice respiratory care to an applicant without requiring him to pass an examination if the applicant:

(a) is currently licensed to practice respiratory care under the laws of another state, territory, or country if the board considers the qualifications for licensure to be equivalent to those required in this state; or

(b) holds credentials, conferred by the national board for respiratory care, as a certified respiratory therapy technician or a registered respiratory therapist and affirms under oath that his credentials have not been suspended or revoked.

(3) A person holding a license to practice respiratory care in this state may use the title "respiratory care practitioner" and the abbreviation "RCP".

NEW SECTION. Section 8. Renewal of license -- application and fee. (1) A respiratory care practitioner's license expires 1 year from the date of issuance.

(2) A licensee may renew his license by:

(a) filing an application with the board on a form approved by the board;

(b) paying a renewal fee in an amount established by the board; and

(c) documenting that he has completed the continuing education requirements prescribed by the board.

(3) An application for renewal of a license made within 90 days after expiration of the license is timely, and the rights and privileges of the applicant remain in effect during that period.

NEW SECTION. Section 9. Temporary permit. (1) The board may issue a temporary permit to practice respiratory care for a period of 1 year, pending receipt of an application for licensure and upon payment of a temporary permit fee in an amount established by the board. To receive the permit, the applicant shall demonstrate in writing, confirmed by oath, that he:

(a) has applied for licensure by reciprocity pursuant to [section 7(2)]. If the board considers the application and denies it, the temporary permit shall lapse.

(b) has taken the examination for licensure and is awaiting the results; or

(c) is a student respiratory care practitioner who expects to graduate within 30 calendar days of his application.

(2) Upon expiration of the permit and payment of an additional fee in an amount established by the board, the board may issue a permit for an additional period not to exceed 1 year pending reexamination or compliance with the provisions of [section 7].

(3) An applicant who reapplies for a temporary permit

after he has abandoned a previous application is not entitled to a permit.

NEW SECTION. Section 10. Revocation, suspension, or refusal to renew license. The board may, after notice and hearing, revoke, suspend, or refuse to issue a license or permit; refuse to renew a license to practice respiratory care; or take other appropriate disciplinary action if the board finds that an applicant or respiratory care practitioner:

(1) is guilty of fraud or material misrepresentation in obtaining or attempting to obtain a license or renew a license to practice respiratory care;

(2) is guilty of gross negligence, incompetency, or misconduct in the practice of respiratory care;

(3) is habitually intemperate in the use of narcotic drugs, alcohol, or any other drug or substance that impairs the user physically or mentally;

(4) has obtained, possessed, used, or distributed illegal drugs or narcotics;

(5) is guilty of unprofessional conduct as defined by the board or is guilty of moral turpitude;

(6) has practiced respiratory care after his license or permit has expired or been suspended or revoked;

(7) has practiced respiratory care under cover of any permit or license illegally or fraudulently obtained or

issued; or

(8) has aided or abetted others in the violation of any provision of this section or the rules adopted under this section.

NEW SECTION. Section 11. Duty to report violations -- immunity from liability. (1) Notwithstanding any provision of state law regarding the confidentiality of health care information, a respiratory care practitioner shall report to the board any information that appears to show that another respiratory care practitioner is:

(a) mentally or physically unable to engage safely in the practice of respiratory care; or

(b) guilty of any act, omission, or condition that is grounds for disciplinary action under [section 10].

(2) There is no liability on the part of a respiratory care practitioner and no cause of action may arise against a respiratory care practitioner who in good faith provides information to the board as required by subsection (1).

NEW SECTION. Section 12. Penalty. A person convicted of violating any provision of [sections 1, 2, and 4 through 13] is guilty of a misdemeanor and shall be fined an amount not to exceed \$500, or shall be imprisoned in a county jail for a term not to exceed 6 months, or both.

NEW SECTION. Section 13. Deposit of fees. All fees and

state special revenue fund for the board's use subject to 37-1-101(6).

NEW SECTION. **Section 14.** Licensure -- grandfather provision. The board shall grant a license to practice respiratory care without examination or completion of the requisite educational program to a person who has been performing respiratory care in this state for at least 1 year on [the effective date of this section].

NEW SECTION. **Section 15.** Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 16.** Codification instruction. (1) [Section 3] is intended to be codified as an integral part of Title 2, chapter 15, part 18, and the provisions of Title 2, chapter 15, part 18, apply to [section 3].

(2) [Sections 1, 2, and 4 through 13] are intended to be codified as an integral part of Title 37 and the provisions of Title 37 apply to [sections 1, 2, and 4 through 13].

NEW SECTION. **Section 17.** Effective dates. [Sections 3 through 5, 14 through 16, and this section] are effective on passage and approval.

In compliance with a written request, there is hereby submitted a Fiscal Note for HB0620, as introduced.

DESCRIPTION OF PROPOSED LEGISLATION:

An act regulating the practice of respiratory care; establishing a quasi-judicial Board of Respiratory Care Practitioners with rulemaking authority; requiring licensure or a temporary permit for respiratory care practitioners; requiring fees for a temporary permit and licenses which are deposited to the special revenue fund for the Board's use; providing penalties; requiring practitioners to report certain conduct and providing immunity for reporting; and providing effective dates.

ASSUMPTIONS:

1. During the first year, the Board of Respiratory Care Practitioners will license 300 persons, conduct 10 examinations, issue 30 temporary permits, and issue 5 inactive licenses. During the second year, the Board will issue 30 new licenses; conduct 10 examinations; renew 300 licenses; issue 30 temporary permits; process 10 late renewals; and process 5 inactive licenses.
2. The board will meet three times per year. The board will need two days to conduct its business.
3. Board expenses will include per diem, travel, supplies, communications, postage, printing and administrative overhead.
4. The Professional and Occupational Licensing Bureau (POL Bureau) will collect license fees and process the adoption of rules, applications and licenses, examinations, registry of licensees, administrative support for disciplinary procedures, reciprocity licenses, and board meetings. These additional services will require an additional 0.25 FTE in the POL Bureau. Administrative overhead charges for the above services must be reflected in the POL Bureau.

FISCAL IMPACT:Expenditures:

	FY 92			FY 93		
	Current Law	Proposed Law	Difference	Current Law	Proposed Law	Difference
Personal Services	0	1,500	1,500	0	1,500	1,500
Operating Expenses	0	14,515	14,515	0	12,400	12,400
Equipment	0	750	750	0	0	0
Total	0	16,765	16,765	0	13,900	13,900

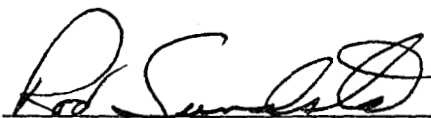
Funding:

State Special Revenue	0	16,765	16,765	0	13,900	13,900
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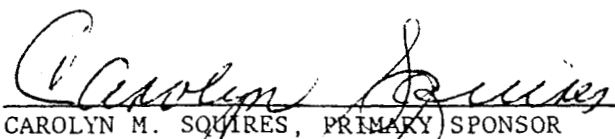
Revenues:

Practitioners fees (02)	0	23,600	23,600	0	19,700	19,700
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Net Effect:	0	6,835	6,835	0	5,800	5,800
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ROD SUNDSTED, BUDGET DIRECTOR
Office of Budget and Program Planning

2-9-91
DATE


CAROLYN M. SQUIRES, PRIMARY SPONSOR
Fiscal Note for HB0620, as introduced

2/11/91
DATE

HB620

CHAIRMAN--ANGELA RUSSELL
NORMAL SCHEDULE==> SITE: ROOM 312-2

DAYS: TU,TH

TIME: 3:00 P.M.

SECRETARY--JEANNE FLYNN KRUMM

BILL NO	REFER DATE	HEARING DATE	CONSIDERATION DATES	COMMITTEE ACTION	REREFERRED TO COMM	DATE OUT
HB0516	1/31	2/11		DO PASS		2/12
LEE, THOMAS			CONSENT FOR MEDICAL TREATMENT OF YOUTH AT STATE YOUTH CORRECTIONS FACILITIES			
HB0521	1/31	2/13		DO PASS		2/14
DOLEZAL, ED			ADDING TO THE DUTIES AND RESPONSIBILITIES OF THE DEPARTMENT OF INSTITUTIONS			
HB0530	1/31	2/13		PASS AS AMENDED		2/19
BROOKE, VIVIAN			PROHIBIT DISABILITY/LIFE INSURERS FROM DISCRIMINATING FOR CERTAIN CONDITIONS			
HB0545	2/01	2/15		DO PASS		2/16
NELSON, THOMAS			GENERALLY REVISE THE LAWS RELATING TO MEDICAID			
HB0548	2/01	2/15		DO PASS	APPROPRIATIONS	2/16
BROOKE, VIVIAN			AMEND VICTIM COMPENSATION TO PROVIDE BENEFITS TO RELATIVE OF INJURED VICTIM			
HB0564	2/01	2/15		TABLED ON 02/15		
COCCHIARELLA, VICKI			REQUIRE PARENTS TO PAY FOR COURT-ORDERED TREATMENT OR SERVICES FOR YOUTH			
HB0592	2/04	3/08		TABLED ON 03/12		
CROMLEY, BRENT			PROVIDE FOR PRESCRIPTION MONITORING OF CONTROLLED SUBSTANCES			
HB0596	2/04	2/15		DO PASS		2/16
O'KEEFE, MARK			PROHIBIT HOUSING DISCRIMINATION ON MARITAL STATUS			
HB0604	2/05	2/20		PASS AS AMENDED		2/22
BROWN, JAN			ALLOW ADULTS TO OBTAIN INFORMATION DISCLOSING BIRTH OUT OF WEDLOCK			
HB0620	2/05	2/20		DO PASS		2/21
SQUIRES, CAROLYN			LICENSURE FOR RESPIRATORY CARE, TO ESTABLISH A RESPIRATORY CARE BOARD			
HB0627	2/05	2/20		DO PASS	APPROPRIATIONS	2/21
ELLIOTT, JIM			REIMBURSE EXPENSES OF THE LOCAL SENIOR CITIZENS' OMBUDSMAN			

MINUTES

MONTANA HOUSE OF REPRESENTATIVES 52nd LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By Rep. Angela Russell, Chair, on February 20, 1991, at 3:20 p.m.

ROLL CALL

Members Present:

Angela Russell, Chair (D)
Tim Whalen, Vice-Chairman (D)
Arlene Becker (D)
William Boharski (R)
Jan Brown (D)
Brent Cromley (D)
Tim Dowell (D)
Patrick Galvin (D)
Stella Jean Hansen (D)
Royal Johnson (R)
Betty Lou Kasten (R)
Thomas Lee (R)
Charlotte Messmore (R)
Jim Rice (R)
Sheila Rice (D)
Wilbur Spring (R)
Carolyn Squires (D)
Jessica Stickney (D)
Bill Strizich (D)
Rolph Tunby (R)

Staff Present: David Niss, Legislative Council
Jeanne Krumm, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

HEARING ON HB 620

Presentation and Opening Statement by Sponsor:

REP. CAROLYN SQUIRES, House District 58, Missoula, stated that this bill requires respiratory therapists to become licensed and regulated by the State of Montana. The purpose of the bill is to protect the public from respiratory care practitioners (RCPs) who are not qualified to provide confident care in the health care profession and to ensure a minimum level of training for practice of this allied health care profession. Montana has more than 300 RCPs presently working in hospitals, other health care facilities, and in home health care agencies. RCPs are called upon to notify increasingly sophisticated medical services. They are allowed to administer medications and perform in basic

procedures such as arterial cultures and invasion. These procedures require the increasing level of skill and training. There is no requirement that respiratory care can practice under qualified medical direction. There is no continuing education requirement in place for RCPs. We need this licensure bill to ensure these things. The hospital association may tell you that licensing RCPs will increase hospital costs of employed RCPs, but our research shows no evidence of this. The market dictates what people are paid, not the fact that they are licensed. You may wonder why individual hospitals are home health care agencies themselves and assure competency of those who work for them as RCPs. The problem is that not all hospitals have standard programs to ensure a high level of care and not all practitioners work in hospitals, many work for home health care agencies and there is no way of ensuring their competency.

Proponents' Testimony:

Mike Riggins, Montana Society for Respiratory Care, submitted written testimony. EXHIBIT 1

Walter Fairfax, M.D., Montana Society for Respiratory Care, stated that he supports the effort to recent professionals of the allied health care workers, particularly people involved in taking care of critically ill persons, as well as chronically ill persons in in-patient and out-patient settings. This bill would allow professional organizations and professional practice that is developed to ensure the quality of care that we expect. We expect increasing things from them in the future and only through this sort of effort will this provide for the people of Montana.

Earl Thomas, Director American Lung Association of Montana, submitted written testimony. EXHIBIT 2

Mary McCue, Montana Society for Respiratory Care, submitted written testimony. EXHIBIT 3, 4 & 5

Rich Lundy, Montana Society for Respiratory Care, stated that he is the author of this bill on respiratory therapists.

Opponents' Testimony:

Jim Ahrens, President, Montana Hospital Association, stated that the bill is well drafted and is a matter of philosophy from the Hospital Associations view. MHA has a longstanding position against licensure of new categories. There are currently 300 respiratory therapist practicing in hospitals and they are practicing safely. Hospitals also have a congressional process and are subject to a board and decisions that are passed on down. The professionalism is there already and the people that are here today demonstrate that, the question is whether or not licensure enhances professionalism.

Questions From Committee Members:

REP. JOHNSON asked if the respiratory therapist could be put under the public board if it was established. Mr. Riggins stated that yes it would, but it would also depend on the make up of that board and what involvement we would have with that.

REP. JOHNSON asked if there are only 300 people in the state and you are going to charge \$50 dues, that is only \$1,500 and there are more than three meetings a year. Mr. Riggins stated that the fiscal note shows that there is a surplus each year as part of the center of the application process.

REP. TUNBY asked what the grandfather clause in the bill said. Ms. McCue stated that the grandfather clause says they have to have worked for a year. There are people who have been working who have not taken the exams and don't have the one or two programs. We did not want to exclude all of them.

REP. WHALEN asked if this legislation went through the Sunrise Committee and what was the position of the Sunrise Committee. Ms. McCue stated that it went through the Sunrise Committee and they recommended that they be licensed.

Closing by Sponsor:

REP. SQUIRES stated that the proponents have done a great job in completing the draft for this licensure bill. In response to the question about the board, no we do not want to go on that board. We consider ourselves scientific, therefore we would like to stay independent. In response to the fiscal note the funds were calculated and there is a certain amount of dollars in reserve and there is the appropriate amount that funds the board adequately and they would have the FTEs.

EXECUTIVE ACTION ON HB 620

Motion: REP. SQUIRES MOVED HB 620 DO PASS.

Discussion:

REP. MESSMORE stated that she support HB 620.

REP. DOWELL stated that he supports HB 620.

Vote: Motion carried 19-1 with REP. KASTEN voting no.

HEARING ON HB 627

Presentation and Opening Statement by Sponsor:

REP. JIM ELLIOTT, House District 51, Trout Creek, stated that this bill deals with the funding program for senior citizen ombudsman (SCO). The SCO is a federal mandate that the federal government gives us without also giving us any money to carry it out. The state must have the program in order to get money to

HOUSE OF REPRESENTATIVES

HUMAN SERVICES AND AGING COMMITTEE

ROLL CALL

DATE 2-20-91

NAME	PRESENT	ABSENT	EXCUSED
REP. ANGELA RUSSELL, CHAIR	✓		
REP. TIM WHALEN, VICE-CHAIR	✓		
REP. ARLENE BECKER	✓		
REP. WILLIAM BOHARSKI	✓		
REP. JAN BROWN	✓		
REP. BRENT CROMLEY	✓		
REP. TIM DOWELL	✓		
REP. PATRICK GALVIN	✓		
REP. STELLA JEAN HANSEN	✓		
REP. ROYAL JOHNSON	✓		
REP. BETTY LOU KASTEN	✓		
REP. THOMAS LEE	✓		
REP. CHARLOTTE MESSMORE	✓		
REP. JIM RICE	✓		
REP. SHEILA RICE	✓		
REP. WILBUR SPRING	✓		
REP. CAROLYN SQUIRES	✓		
REP. JESSICA STICKNEY	✓		
REP. BILL STRIZICH	✓		
REP. ROLPH TUNBY	✓		

CS05HUMSER.MAN

11:00
2-21-91
JDB

HOUSE STANDING COMMITTEE REPORT

February 21, 1991

Page 1 of 1

Mr. Speaker: We, the committee on Human Services and Aging
report that House Bill 620 (first reading copy -- white) do
pass.

Signed: _____
Angela Russell, Chairman

DATE 2-20-91
HB 620

Legislative Audit Committee

State of Montana



Report to the Legislature

December 1990

Sunrise Report -- 1991 Biennium

Summary of Sunrise Proposals for the Licensure of:

- ▶ **Respiratory Care Practitioners**
- ▶ **Naturopathic Physicians**
- ▶ **Midwives**
- ▶ **Auctioneers**
- ▶ **Property Managers**

Direct comments/inquiries to:
Office of the Legislative Auditor
Room 135, State Capitol
Helena, Montana 59620

90SP-45

January 30, 1985

Mr. Gary Brown
Respiratory Therapy
St. Luke's Hospitals
Fargo, North Dakota 58122

RESPIRATORY THERAPY SERVICES

Respiratory therapy services in the state of North Dakota have been observed in the audit process and also in the individual group studies of cost per hospital day.

It is apparent by these studies that respiratory therapy in some areas has been used excessively with possibly little professional expertise to monitor or deliver these services. Without the proper education and/or background, the services cannot be supervised properly, nor would symptomology of the patient be conferred correctly to the physician. Without this expertise, services as a rule are not discontinued timely or changed according to the condition of the patient.

It has become apparent from audits completed that the cost and usage of respiratory services is a greater section of the total bill when the services are delivered by the uneducated individual.

Actual statistics for a past year for a particular bed-sized hospital were \$7.04 per day for educated providers and \$22.76 for the uneducated provider. Another bed-sized hospital statistic was \$12.50 for the educated provider while \$20.87 for the uneducated provider.

It appears the proper training and education are vital for the proper delivery of respiratory services while keeping the safety and well-being of the patient in mind as well as the total dollar spent for this service.

Marlene Moderow R.N.

MARLENE MODEROW, R.N.
Medical Review Field Auditor

PROCEDURE	DESCRIPTION OF THERAPY	INDICATIONS FOR THERAPY	HAZARDS/COMPLICATIONS
Endotracheal intubation	Emergency or elective placement of endotracheal tube into the trachea or respiratory tract in order to provide an airway and/or ventilate a patient, includes infants, children, adults.	Cardiac or respiratory arrest. Any other event whereby patients can no longer breathe on their own or require possible assisted ventilation. Routinely done for long operative procedures.	1. Improper placement of tube resulting in asphyxiation, hypoxia (lack of oxygen to brain and other vital organs), carbon dioxide narcosis. 2. Damage and/or paralysis of vocal cords. 3. Rupture and hemorrhage to esophagus and/or trachea. 4. Atelectasis--collapsed lung. 5. Pneumothorax (lung collapse). 6. Dental fractures. 7. Aspiration of blood, stomach contents. 8. Infection.
Suctioning	A procedure necessary for removal of secretions from endotracheal, tracheostomy tubes or the respiratory tract directly to maintain a patent, functioning airway.	Patients that have endotracheal / tracheostomy tubes in place. Patients unable to cough to remove secretions. Newborns or infants with pulmonary distress.	1. Sudden death syndrome secondary vagal stimulation. 2. Cardiac arrest or standstill. 3. Cardiac arrhythmias. 4. Hypoxia--oxygen lack to brain, vital organs. 5. Bleeding/hemorrhage, damage to trachea. 6. Infection.

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PROCEDURE	DESCRIPTION OF THERAPY	INDICATIONS FOR THERAPY	HAZARDS/COMPLICATIONS
Arterial Blood Gas Sampling	A procedure whereby a therapist inserts a needle into an artery (radial, brachial or femoral) to obtain arterial blood for analysis. Determines the need for oxygen therapy and amounts of oxygen and carbon dioxide in blood. Determines metabolic status (A/B).	To determine cardio-respiratory status of patients: Including patients with-- Shortness of breath Mechanically ventilated patients Kidney failure Trauma victims Diabetic crisis Cardiac/respiratory arrest--pre-arrest state Drug overdose Post-operative patients	1. Damage or destruction of artery resulting ultimately in amputation of affected limb. 2. Hematoma/hemorrhage. 3. Damage/paralysis of nerve adjacent to sampling site. 4. Infection. 5. Intense pain due to poor technique. 6. Air embolus.
C.P.R. - Cardio-Pulmonary Resuscitation	A life saving procedure requiring immediate and appropriate assessment and response to a patient with cardiac or respiratory arrest. Includes providing airway and artificial ventilation along with external cardiac compressions.	Cardiac or respiratory arrest. Newborn-premature infants requiring resuscitation measures at birth. Airway obstruction-choaking victims.	1. Improper technique can result in death. 2. Fractured ribs, sternum 3. Liver lacerations. 4. Gastric distention (air in stomach) with resultant aspiration/pneumonitis. 5. Fractured necks in infants/children. 6. Pneumothorax--burst/collapsed lung in infants/children.

HB

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2-20-91

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PROCEDURE	DESCRIPTION OF THERAPY	INDICATIONS FOR THERAPY	HAZARDS/COMPLICATIONS
Oxygen Therapy	Oxygen is a drug administered by a mask, nasal cannula, tent (infants/children) or positive-pressure demand valves.	Hypoxemia -- low oxygen content in the blood. Examples of patients requiring oxygen are: Chronic lung patients Emphysema Pneumonia Asthma Bronchitis Cystic Fibrosis Cardiac patients *There are approximately 8,000 patients in New Jersey <u>AT HOME</u> on oxygen.	1. Oxygen toxicity--results in damage to lung tissue. 2. Blindness in infants. 3. Can eliminate the drive to breathe in some patients (COPD). 4. Infection.
Postural Drainage Chest Percussion	A mode of therapy requiring proper positioning of patient for safe/effective drainage of lung segments.	Any disease state requiring removal of mucous secretions from lungs. Cystic Fibrosis Pneumonia Bronchitis Asthma Emphysema	1. Can increase intracranial pressure--patient must be properly monitored--especially infants--may cause intracranial bleeding. 2. Spread of infection to another lung segment. 3. Aspiration. 4. Pneumothorax.

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PROCEDURE	DESCRIPTION OF THERAPY	INDICATIONS FOR THERAPY	HAZARDS/COMPLICATIONS
Aerosol Therapy	A mode of therapy to dispense medication directly to respiratory tract. Given by mask or hand-held device. Can be given with compressed air or oxygen to infants, children, adults. Drugs used include: Sympathomimetic agents (bronchodilators) Antibiotics Antifungal agents Mucolytics	Patients with shortness of breath (SOB) due to: Asthma Emphysema Chronic Lung Disease Cystic Fibrosis Tuberculosis Pneumonia Bronchitis Retained Secretions (mucous) Inhalation burns (heat, smoke) Chemical inhalation	1. Irregular heart rates/rhythms. Tachycardias/arrhythmias leading to cardiac arrest. 2. Effects blood pressure. 3. Can effect central nervous system causing tremors, agitation, insomnia. 4. Nausea. 5. Overhydration--fluid overload with resultant heart failure from excessive use of ultra-sonic therapy. 6. Allergic reactions to medications. 7. Infection from improperly dispersed medication. 8. Inherent problems from over-use of oxygen (see Oxygen Therapy). 9. Can aggravate asthmatic attack if improperly administered.
IPPB Therapy	A mode of therapy to disperse medication directly to respiratory tract. Similar to aerosol therapy, but IPPB (Intermittent Positive Pressure Breathing) is administered under pressure to the lungs. Can be used with compressed air or oxygen to children, adults. Drugs include: Sympathomimetic agents Antibiotics	Patients with S.O.B. See Aerosol Therapy (above)	Same hazards as aerosol therapy and 1. Pneumothorax-- air which does not belong in chest cavity requiring emergency insertion of chest tube to prevent cardio-respiratory arrest. 2. Decreases cardiac output. Can result in arrest. 3. Oxygen complications.

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PROCEDURE	DESCRIPTION OF THERAPY	INDICATIONS FOR THERAPY	HAZARDS/COMPLICATIONS
Mechanical Ventilation Respirators	A life support device-machine to which the patient is directly attached via endotracheal/tracheostomy tube for the purpose of providing ventilation (breathing) for the patient.	Any condition affecting the ability of the person to breathe thereby maintaining proper oxygen, carbon dioxide levels, adequate metabolic status to maintain life. Respiratory/Cardiac Failure Trauma/Shock Post Operative complications Anesthetic Overdose Drug Overdose Ethanol poisoning (alcohol overdose) Foreign Body Obstruction Premature Infants	Due to the fact that once a patient is placed on a life support system/ventilator, the ultimate hazard secondary to mechanical failure, poor monitoring of patient is, <u>death</u> , permanent brain or vital organ destruction. Some of the major medical emergencies that arise are: Deceased cardiac output Deceased blood pressure Deceased urinary output Barotrauma-pneumothorax Collapsed lung Oxygen toxicity Severe metabolic imbalances Severe electrolyte imbalance Infection Tracheal hemorrhage

HB 620



AMERICAN LUNG ASSOCIATION OF MONTANA

Christmas Seal Bldg. — 825 Helena Ave.
Helena, MT 59601 — Ph. 442-6556

EARL W. THOMAS
EXECUTIVE DIRECTOR

2
DATE 2-20-91
HB 620

TO: HUMAN SERVICES COMMITTEE
CHAIRMAN: ANGELA RUSSELL

ROOM ³¹²~~211~~-2 Wednesday February 20, 1991

FROM: EARL THOMAS, EXECUTIVE DIRECTOR

SUBJECT: HB620 - SPONSOR CAROLYN SQUIRES
"LICENSURE FOR RESPIRATORY CARE. ESTABLISHING A RESPIRATORY
CARE BOARD:

THE AMERICAN LUNG ASSOCIATION OF MONTANA SUPPORTS HB 620
BECAUSE WE BELIEVE IT WILL PROTECT THE PUBLIC FROM UNQUALIFIED
RESPIRATORY CARE.

THE FIELD OF RESPIRATORY CARE IS A VERY DEMANDING ONE. ONE
ONLY NEED LOOK AT THE COURSE OF STUDY AT EITHER OF MONTANA'S
TWO RESPIRATORY THERAPY SCHOOLS TO RECOGNIZE WHAT A RIGOROUS
AND SOPHISTICATED FIELD THIS IS.

RESPIRATORY CARE IS AN EXPANDING FIELD BECAUSE RESPIRATORY
ILLNESS IS ONE OF THE FASTEST RISING DISEASES IN THE UNITED
STATES AND MONTANA CONSISTENTLY RANKS IN THE TOP FIVE.

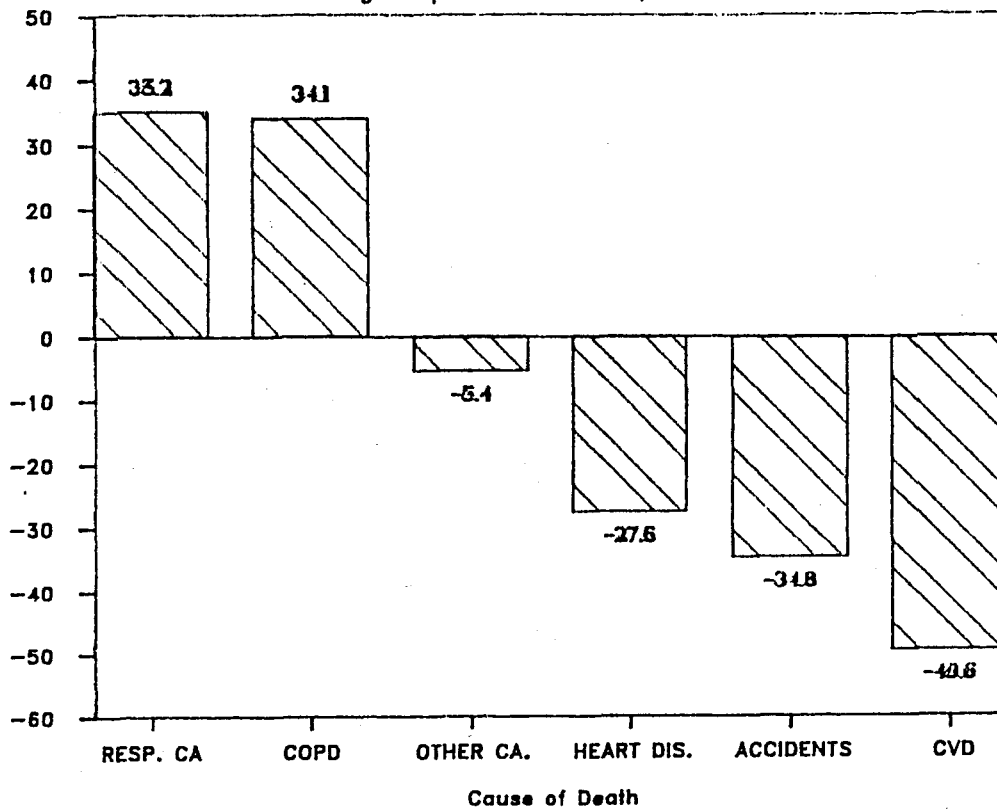
A NATIONAL HEALTH INTERVIEW SURVEY DONE IN 1987 SHOWED THAT
PERSONS SUFFERING FROM CHRONIC BRONCHITIS, EMPHYSEMA AND ASTHMA
INCREASED 75.9% FROM 1970 to 1987. THE ATTACHED YELLOW SHEET
PROVIDES FURTHER SUPPORT ON HOW LUNG DISEASE DEATHS ARE
INCREASING.

SINCE LUNG ILLNESSES ARE 75 TO 85% PREVENTABLE. WE ARE NOW
PAYING THE PRICE FOR THE 43% OF THE POPULATION WHO SMOKED IN
THE 1960'S. WE ARE PROUD TO STATE THAT MONTANA CURRENTLY
HAS ONE OF THE LOWEST SMOKING RATES IN THE COUNTRY WITH LESS
THAN 20%. HOWEVER IT WILL BE MANY YEARS BEFORE WE SEE THE
BENEFITS OF THIS.

RESPIRATORY CARE PRACTITIONERS ARE NOT ONLY IN HOSPITALS AND
CLINICS BUT ALSO IN THE PATIENTS HOMES PROVIDING CARE AND
EDUCATION.

PLEASE GIVE HB 620 A DO PASS RECOMMENDATION TO INSURE THE
CONTINUED HIGH QUALITY OF RESPIRATORY CARE

Age-Adjusted Death Rates, 1970-84



Source: NCHS Monthly Vital Statistics Report
Final Mortality Statistics, 1970-84.

COPD: COPD and Allied Conditions (includes Asthma)
CVD: Cerebrovascular Disease
CA: Cancer

ICD Revision in Use:

1970-1978: Eighth Revision COPD = 490-493, 519.3
1979-1984: Ninth Revision COPD = 490-496

Some Facts About House Bill 620
Sponsored by Rep. Carolyn Squires
Licensure of Respiratory Care Practitioners

--- Will respiratory care practitioners be given an exclusive license to practice respiratory care?

No, this bill allows other health care providers who are allowed under their own scope of practice to perform respiratory care to continue to do so.

--- How many states currently license respiratory care practitioners?

31 states have some form of licensure and regulation.

--- Do present statutes guarantee quality respiratory care? Why is licensure necessary?

Due to the legal liability of personnel departments that prevents them from providing detailed information regarding a job applicant, it is difficult for hospitals and other employers to know if a prospective respiratory care practitioner employee is competent. This allows those few incompetent practitioners to move from job to job without detection. Licensure and regulation provide a means to ensure quality respiratory care. There also presently are no mandatory continuing education requirements to ensure continuing quality respiratory care.

The Joint Commission on the Accreditation of Hospitals (JCAH) requirements that accredit hospitals has not dealt with the problem of incompetent practitioners and does not mandate continuing education.

--- Will licensure raise the cost of employing respiratory care practitioners?

No. Regarding salaries, the market dictates what respiratory care practitioners are paid, not the fact the group is licensed. As to insurance reimbursement issues, Medicare, Medicaid, and private insurance policies already provide for reimbursement of respiratory care services, for both inpatient and outpatient services. This bill does not add a new group to the list of health care providers seeking reimbursement for their services.

EXHIBIT 7

DATE 2-20-91

HB 620

I. Introduction

- A. My name is Nancy Whitmer, I am a former Special Education teacher and the mother of 6 boys, one 19 who is currently on a PLV 100 ventilator.
- B. I am here as a concerned citizen as well as a concerned parent to advocate for the Respiratory Therapists and their proposal, seeking licensure for those therapists in their profession.
- 1) It was anxiety provoking for me when I was informed that the (250) Respiratory Therapists in Montana are the only allied healthcare professionals involved in life-saving and life sustaining procedures which are not licensed. I had always assumed they were.
 - a) It did explain, though, the many instances which we have had unpleasant experiences with Respiratory Care Therapists and those who worked among them.
 - b) Obviously, with no Board to establish minimum standards or levels of competency: ¹ there are no controls to prevent the public from the unqualified practice of respiratory care or ² from the unprofessional conduct of persons even though they are qualified.

The general public in many instances, is no better off than a lottery player ... when referred, you hope to get a currently educated, competent Respiratory Therapist ... many times a respiratory crisis occurs before the layman realizes he as a problem.

- c) As a teacher, my profession demands that those in it return to school at regular intervals to stay current and updated in their respective fields. It demands, that if they are returning after a lengthy absence they need to take even more credits and be re-certified or they may not re-enter the classroom.
 - 1) Kids in the classroom would not be at risk in a life/death situation with an out-dated, under skilled teacher ... but the Respiratory Therapist who operates in that same manner exposes his clients to life threatening risks ... skills of the profession require continuous updating as modern technology advances.
 - 2) Even the hairdresser who cuts my hair is required by state law to have a license, so is the manicurist. They undergo periodic, unannounced inspections from the state to ensure public health and safety.

These above mentioned professions have the "tools" through STATE BOARDS, EXAMS, requirements for continuing education etc. to police their own professions, THE RESPIRATORY THERAPISTS DO NOT.

II. In my own personal experiences with my son's respiratory care, we have encountered at least 20 different Respiratory Therapists in the last 13 years.

A) Jon was diagnosed as having Duchinne Muscular Dystrophy at age 6 in 1977. He was given a life expectancy of the age of 12 - at that time.

- 1) Today, at 19. He is a freshman at Eastern Montana College, having graduated with honors from Billings Senior High School 1989.
- 2) He is alive only because of the technological advances in the field of Respiratory Management. In 1977 respiratory care for Jon was merely a lung exercise, breathing in and out with a book on his chest. In 1980 he had a positive pressure machine which would automatically inflate his lungs (as would a balloon).

These were simple procedures - even his younger brothers could help with them.

3) In 1987 Jon went into respiratory failure. Since then we have used:

- 1) Aerosol breathing treatments - medication prescribed and inhaled directly into lungs.
- 2) Diaphragmatic rocking bed (expl.)
- 3) Iron lung (no one familiar at time - too young)
- 4) Porta lung - with negative pressure ventilators
- 5) PLV 100 with nose piece - a positive pressure ventilator.

a) This machine represents the ultimate in high technology and the advances being made in the respiratory field. Ours is the only one in Billings. There currently is only 1 Respiratory Therapist who has any working knowledge of the operation.

As you can see, in a 10 year period ... the gradual increase in our respiratory needs were met by modern technology, (sometimes modern therapists, reaching back in time to adapt to our needs). In the 10 year span we also saw the skills of the various Respiratory Therapists attending to Jon challenged to grow along with our needs. The skills needed in 1977 differed vastly from those needed in 1987 to 1990. Without continuing education for Therapists their performance will be sub-standard, and so will the care delivered to the patient.

-2-20-41
HB 620

B. Children like Jon, and those having other respiratory diseases (Cystic Fibrosis, Myesthenia Gravis, etc.), and adults with emphysema and heart ailments all live longer, more productive lives thanks to the diagnostic tools, and modern advances implemented in the Respiratory field.

- 1) They will not give us maximum benefit, or any at all, if the Respiratory Therapists are not acquainted with them or if they have not kept abreast with the changes in their field. We can be assured this thru licensure, Board, ongoing education requirements, and setting minimum standards.
- 2) Many skills are involved today; evaluation, testing. Machines used for some of this look like the "dash board" of a spaceship.

Blood gas studies are used to determine the oxygen levels in the blood, this is accomplished by withdrawing blood from a main artery in the patient's body (similar to those in dye studies done by Medical Doctors).

The Respiratory Therapists today are part of a profession that requires them to do more than roll an O₂ tank into a patient's room or administer aerosol treatment to a child with asthma or croup.

C. It is the Respiratory Therapist, in our experience, who tests and evaluates patients so that a respiratory program can then be prescribed by a doctor.

- 1) It is the Respiratory Therapist who draws the arterial blood gases to obtain blood samples (these tell us the levels of O₂ and CO₂ in the blood). This has been literally a life and death situation in Jon's case, levels too high can result in coma and death.
- 2) It is the Respiratory Therapist who trains the families in home care of the patient and makes house calls to "trouble shoot" any problems and to help with a solution.

D. The Respiratory Therapist is, in essence, the eyes and ears for the Pulmonary Doctor (reporting to him the findings).

- 1) The Respiratory Therapist's expertise in the field, his observational skills, evaluation procedures, knowledge and experience CAN MAKE A DIFFERENCE, CAN SAVE A LIFE.
 - a) Sloppy and unprofessional conduct, whether it be due to ignorance or not, is negligence and can cost a life.

2-26-91
 BB 620

b) We have had experiences with both;

1) In one instance when Jon was in the hospital for respiratory failure, 2 liters of O² was prescribed for him (a routine prescription since the O² level in his blood was low). For Jon, with Muscular Dystrophy, that was too much, he went into a CO² induced coma. It was an alert Respiratory Therapist who observed this and recognized that extra O² was being "piped" in but the CO² (left over, deadly air) was not being exhaled. Immediately the O² was reduced to 1/4 liter. Jon was almost immediately more alert.

a) Families of patients are not trained to evaluate the unexpected or assess out of the ordinary medical problems. I was not, at that time. Today I have learned to be a more informed parent. Many parents do not have the access that I have had thru medical travels to Seattle and Dallas. We assume that the person with the white coat and name tag is qualified in his or her profession. Licensure of Respiratory Therapists in Montana would serve to assure families, patients and co-workers that some set standards are being met.

b) I do not pretend to have the expertise to evaluate a professional unless it's blatant, open, or obvious.

1) This occurred when Jon was in the Iron Lung. After the unpleasant occurrence with too much oxygen, it was charted that he should have NO O² when in the Lung.

One Respiratory Therapist, who held a position higher than the average R.T. and who also held himself in quite high esteem, came into Jon's room one night and began to hook up the O². I objected saying the doctor had ordered it ceased at night when in the Lung. He was insistent that he was proper in administering it, I was insistent also - would not allow it - I strongly informed him that he should call the doctor. So he did call the doctor and was told it was ON THE CHART - NO O² ... HE HAD NEGLECTED TO READ IT.

a) This incidence was unnecessary and unprofessional. His personality had caused problems before - not just among patients. He was a definite irritant to some of his peers.

b) He may have been experienced and qualified, but he was not professional. We were relieved to see, upon a return visit to the hospital, that he no longer worked there (we had nothing to do with this). The relief was short lived however, when at a later date, I admitted my mother to the other hospital in Billings - I saw him in the hall outside of the Respiratory Unit. I was informed upon inquiry after this that the person had never received formal schooling and was not credentialed.

It is people such as this individual (in the Respiratory field) whether they lack the skills and expertise needed for the practice of high technology Respiratory Care, or maybe they have the skills and credentials, but their conduct is not suited to that of a professional and who may put patients at risk.

Today, there is no "tool" to weed them out, no "Big Brother" so to speak, for fellow Respiratory Therapists to have as a "lever". A State Board and licensure would help accomplish this.

IN MY OPINION, WHICH IS DRAWN FROM 13 YEARS EXPERIENCE WITH RESPIRATORY THERAPY, THERE SHOULD BE NO QUESTION AS TO WHETHER OR NOT THE RESPIRATORY THERAPISTS SHOULD BE LICENSED, BUT HOW SOON IT CAN BE ACCOMPLISHED.

Thank you for your time.

THE RESPIRATORY CENTER



RONALD E. BURNAM, M.D., F.C.C.P.
FREDERICK W. KAHN, M.D., F.C.C.P.
THOMAS P. THIGPEN, M.D., F.C.C.P.

EXH.BIT 5
DATE 2-20-91
HB 620

February 8, 1991

Montana State Legislature
State Capitol
Helena, MT 59624

To Whom It May Concern:

I am writing you in regards to the proposed respiratory care legislature act that is before the current session of the legislature.

I am a practicing physician in Billings and a respiratory specialist. I would like to go on record as being a firm supporter of this type of legislative act.

Respiratory care has expanded rapidly over the past several years with very sophisticated modalities now available both as inpatient and outpatient possibilities. Because of the sophistication of these services that need to be provided I think that it is adamant that there be some mechanism to oversee the training and supervision of the individuals who provide these various services. It seems to me that the way that this bill is proposed it is obvious that a great deal of thought has been put into this and that the public can be assured that people who are providing services are in fact qualified.

Once again, I think this is a good thing to have and I would very much encourage your support.

Sincerely,

Thomas P. Thigpen MD

Thomas P. Thigpen, M.D.

TPT/bjs

THE RESPIRATORY CENTER



RONALD E. BURNAM, M.D., F.C.C.P.
FREDERICK W. KAHN, M.D., F.C.C.P.
THOMAS P. THIGPEN, M.D., F.C.C.P.

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Sincerely,

Thomas P. Thigpen M.D.

Thomas P. Thigpen, M.D.

TPT/bjs

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services & Aging

COMMITTEE

BILL NO. HB 620

DATE 2-20-91

SPONSOR(S) Rep. Caroline Squires

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
RICH LUNDY 901 COUNTRY VIEW DR. BILLINGS	MONTANA SOCIETY FOR RESPIRATORY CARE	✓	
Dave Bunkos Billings, MT	MT Society for Respiratory Care	✓	
MIKE ZWICKER BILLINGS, MT	MT Society for Respiratory Care	✓	
WALTER FAIRFAX, MD BILLINGS, MT	MT MSRC	✓	
Thomas Gelpman Great Falls	MT Society for Respiratory Care	✓	
Michael Biglieri Society Lake, MT	MSRC	✓	
Barb Thomas	AMERICAN LUNG ASSN OF MONTANA	✓	
Mary McCue	mt Soc for Respcare	✓	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS
AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

CHAIRMAN--DOROTHY ECK

NORMAL SCHEDULE==> SITE: ROOM 410

DAYS: M,W,F

TIME: 3:00 P.M.

SECRETARY-CHRISTINE MANGIANTINI

--BILL NO--	REFER DATE	HEARING DATE	CONSIDERATION DATES	COMMITTEE ACTION	REREFERRED TO COMM	DATE OUT
HB0413	2/14	3/08		CONCUR AS AMENDED		3/09
CONNELLY, MARY ELLEN			REDUCE INTERNSHIP FOR DENTURISTS TO 1 YEAR; AMEND CONT. ED REQUIREMENTS			
HB0445	2/16	3/08		CONCUR		3/09
RICE, JIM			REPEAL EXPIRATION DATE OF CERTIFICATE OF NEED LAW			
HB0515	2/27	3/13		CONCUR		3/14
LEE, THOMAS			CLARIFY REQUIREMENTS FOR MEDICAL EXAMS FOR YOUTH COMMITTED TO STATE FACILITY			
HB0516	2/19	3/06		CONCUR		3/07
LEE, THOMAS			CONSENT FOR MEDICAL TREATMENT OF YOUTH AT STATE YOUTH CORRECTIONS FACILITIES			
HB0521	2/20	3/08		CONCUR		3/09
DOLEZAL, ED			ADDING TO THE DUTIES AND RESPONSIBILITIES OF THE DEPARTMENT OF INSTITUTIONS			
HB0545	2/25	3/25		CONCUR		3/26
NELSON, THOMAS			GENERALLY REVISE THE LAWS RELATING TO MEDICAID			
HB0587	2/25	3/13		CONCUR		3/14
JOHNSON, ROYAL			ALLOW BOARD OF MEDICAL EXAMINER TO SET LICENSE RENEWAL DATE; IMPOSE LATE FEE			
HB0620	2/27	3/18		CONCUR AS AMENDED		3/21
SQUIRES, CAROLYN			LICENSURE FOR RESPIRATORY CARE, TO ESTABLISH A RESPIRATORY CARE BOARD			
HB0635	2/20	3/18		CONCUR		3/26
MEASURE, BRUCE			REVISE UNIFORM RIGHTS OF THE TERMINALLY ILL ACT			
HB0640	2/27	3/22		CONCUR		3/23
BROWN, JAN			REVISE THE DEFINITION OF FETAL DEATH			
HB0642	2/27	3/22		CONCUR		3/23
COCCHIARELLA, VICKI			REVISE THE MONTANA CHILD CARE ACT			

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MINUTES

MONTANA SENATE 52nd LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE & SAFETY

Call to Order: By Chairman Dorothy Eck, on March 18, 1991, at
3:35 p.m.

ROLL CALL

Members Present:

Dorothy Eck, Chairman (D)
Eve Franklin, Vice Chairman (D)
James Burnett (R)
Thomas Hager (R)
Judy Jacobson (D)
Bob Pipinich (D)
David Rye (R)
Thomas Towe (D)

Members Excused: None.

Staff Present: Tom Gomez (Legislative Council)
Christine Mangiantini (Committee Secretary)

Please Note: These are summary minutes. Testimony and
discussion are paraphrased and condensed.

HEARING ON HOUSE BILL 620

Presentation and Opening Statement by Sponsor:

Representative Carolyn Squires opened by saying HB 620 is the licensing request for the respiratory therapists. It will require licensing and regulating by the State of Montana. The purpose is to protect the public from respiratory care practitioners that are not qualified to provide competent care as well as ensure a minimal level of training for this allied health care profession. There are more than 300 respiratory care practitioners practicing in Montana. They are allowed to administer medication and perform basic medical procedures which require an increasing level of skill and training. Currently, there is no standard in place that ensures competency and continuing education. There is no requirement that respiratory care be practiced under qualified medical direction. The Hospital Association may tell the committee that licensing respiratory care practitioners will increase hospital costs. Research does not indicate this to be the case.

Representative Squires continued by saying the bill establishes the Board of Respiratory Care and requires all practitioners to be licensed and to satisfy continuing education requirements. Licensing will not result in a shortage of practitioners. Respiratory therapists went through the Sunrise process and the State Auditor recommended licensure. She urged the committee to do pass recommendation. She passed the committee copies of Exhibit #5.

Proponents' Testimony:

The first witness was Michael Biggins, representing the Montana Society for Respiratory Care and director of Respiratory Services at Missoula Community Hospital. See Exhibit #1 for a copy of his testimony and hand-outs.

The second witness was Dr. Nicholes Wolter, representing himself and the Montana Society of Respiratory Care. He said he supported the bill for a number of reasons but especially because of its impact on the quality of care. It is estimated that one-third of all patients admitted to hospitals will receive some type of respiratory care therapy. This profession involves a great deal of judgement in assessing the patient's condition. Those practicing in critical care medicine depend on respiratory care therapists. The therapy is becoming extremely sophisticated. The proper managing of the equipment can make a difference in the patient's survival.

The third witness was Rich Loney, a respiratory care therapist working in Billings and one of the principal authors of the bill. He urged passage.

The fourth witness was Mary McCue, representing the Montana Society for Respiratory Care. She said there is one minor amendment that was overlooked in the House of Representatives. There is language in the statute that deals with the creation of a quasi-judicial board. One member of that board shall be an attorney unless licensure language speaks otherwise. On page 6 of the bill it does not include language about including an attorney. She passed out Exhibit #2, a copy of the proposed amendment and copies of letters.

Mr. Earl Thomas, executive director of the American Lung Association submitted written testimony to the committee. See Exhibit #3.

Opponents' Testimony:

The first witness was Mr. Jim Aherns, president of the Montana Hospital Association. He said they have opposed three licensure bills this session. They met with the respiratory therapists but have a long-standing position about licensure of health care professionals. He said they were opposed to the legislation.

Questions From Committee Members:

Senator Towe asked about the Sunrise process.

Mr. Loney said there were no comments. They worked with the Department of Commerce to set the fees. The vote was 7-1, Representative Simon was opposed.

Senator Towe asked about the number of respiratory therapists practicing in Montana.

Mr. Loney said well over 300. The most recent survey was about 370.

Senator Towe asked about their educational requirements.

Mr. Loney said the National Board of Respiratory Care certification level will be the minimum entry level for the state. Thirty-one other states have implemented licensure and they are all using the same credentials. Three respiratory therapists in Montana have been identified as having on the job training but not formal education. Great Falls offers one and two year programs.

Senator Burnett asked if physicians perform respiratory care services.

Mr. Loney said physicians do perform these services. A variety of physicians perform some of the specialized procedures. He said everything a respiratory care therapist performs is under medical direction.

Senator Hager said he had received good respiratory care during a hospital stay. He asked why the bill was necessary.

Mr. Loney said there is the potential for problems.

Chairman Eck asked if a grandfather clause was included, she continued by saying they did not grandfather any of the licensure bills.

Mr. Loney said once the bill goes into effect all respiratory care therapists are required to complete continuing education. The minimum requirements for licensure are certification by the national board, the minimum education requirement. The dozen people who will get grandfathered in with no formal training. The only requirement is one year documented respiratory care experience at the time the bill is enacted. In Glendive, their program includes a nurses aide and an LPN that are working as respiratory care therapists and are in a formal training program.

Senator Hager asked about the continuing education requirements.

Mr. Loney said there are no requirements. Most hospitals offer programs. The national organization offers correspondence courses.

Closing by Sponsor:

Representative Squire closed by saying it is important to understand a grandfather clause. At the time she started her training as an LPN there was no particular education requirement. When the profession was upgraded we required a GED or high school education. To protect the LPNs that were already practicing we grandfathered them in. Respiratory care will be one of the prime allied health fields. We will probably need more of these types of services. We do not want people using the sophisticated treatments that are not qualified. She urged passage of the bill.

HEARING ON HOUSE BILL 713

Presentation and Opening Statement by Sponsor:

Representative Dick Knox opened by saying this bill will impact slightly the admissions policy and bring the law into conformity. The Montana Center for the Aged serves persons over the age of 55 who have a mental illness and need nursing care but who are not in need of active treatment for their mental illness. A survey of patients in 1990 showed a full range of psychiatric diagnoses among the residents, including mood disorders, personality and organic disorders. Many are not associated with the aging process. This bill clarifies that the patients that are appropriately served are elderly but their mental illnesses are not necessarily related to the aging process.

Proponents' Testimony:

The first witness was Dan Anderson, administrator of the Mental Health division, Department of Institutions. See Exhibit #9 for a copy of his testimony.

The second witness was Kelly Moorse, director of the Board of Visitors. See Exhibit #4 for a copy of her testimony.

The third witness was Hank Hudson, director of the Governor's Office on Aging. The Advisory Council on Aging supports this bill. He said they look forward to letting Montanans know about this bill. He said it is an important way to educate the public about the valuable resource we have in our senior citizens.

Opponents' Testimony:

None.

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ROLL CALLPUBLIC HEALTH, WELFARE
AND SAFETY

COMMITTEE

Date 03/18/9

NAME	PRESENT	ABSENT	EXCUSED
SENATOR BURNETT	X		
SENATOR FRANKLIN	X		
SENATOR HAGER	X		
SENATOR JACOBSON	X		
SENATOR PIPINICH	X		
SENATOR RYE	X		
SENATOR TOWE	X		
SENATOR ECK	X		

The unregulated practice of Respiratory Care in Montana can be an immediate hazard to public health, safety, and welfare.

EXHIBIT NO. 11
DATE 3/18/91

HEALTH AND SAFETY

BILL NO. 620

The constant progressive march of technology in the field of respiratory care and medicine in general, demands highly skilled practitioners. No longer can on-the-job trainees with no formal education be allowed to practice unsupervised. But worse yet, no longer can the practitioner who once long ago passed a national exam and has since not picked up a journal, gone to a class, or kept up in the field in any way.

To prove my point I'll discuss three procedures currently done by respiratory care practitioners in Montana: Arterial Blood Gas Puncture, Intubation of the Trachea, and Aerosol Therapy.

Arterial Blood Gas Puncture

This is a blood sample usually drawn from an artery in the wrist, elbow area, or groin. The gases in this sample which are measured by a gas analyzer are oxygen and carbon dioxide. Other measurements and calculations are also made from this sample.

The difficulty with this maneuver unlike in drawing veinous blood is one cannot routinely see the vessel. The artery is palpated as one does to take their pulse. Then a very sharp needle is inserted at the spot where the strongest pulseatile sensations is felt.

The problems in drawing arterial blood include, some people don't sit still, some people's arteries roll under the skin, veins and nerves run parrallel and nearby arteries.

The first two problems can be dealt with. The latter can cause problems to the health and safety of Montanans. If the sample comes from a vein instead of an artery, erroneous values are reported and if not caught in time, medical intervention which may be hazardous to a patient can be initiated. If a nerve is nicked the pain feels similar to the feeling one gets when bumping their funny bone. Further damage to the nerve and surrounding blood vessels can result when the patient moves while a needle is still in their arm or leg.

Intubation of the Trachea

Placing an artificial airway in a person's trachea for a non-surgical procedure is an event done in an emergency situation. If not done correctly and the error goes unrecognized, a Montanan will die within a few minutes. Even if the error is recognized, the time it takes to remove the airway from the esophagus and again try to intubate the trachea; the person's lungs are not being ventilated with life-sustaining oxygen. Also because the esophagus was intubated instead of the trachea, the stomach had air pumped into it. When the airway is removed the person usually vomits resulting in aspiration of this material into the lung. The tissues of the lung do not function well with the acid of the stomach contents in them.

The question I pose to the people of Montana: Would they want themselves or someone in their family, after being involved in a serious traffic accident near a small town in Montana, be intubated by an unlicensed practitioner who may not have a lot of skill?

Aerosol Therapy

Respiratory care providers aerosolize many therapeutic liquids to be inhaled by patients. Currently one of the most commonly used liquid for asthma is a medication called Albuteral. The dosage for this medication is in tenths of milliliters, e.g., .2ml with .5ml being the recommended maximum dosage. For your information I've provided a copy of the listed side effects of this medication.

Doctors write the order for Albuteral to be given. But suppose, for the sake of discussion, I present a scenario where an error is made in the order:

An 8 year old girl comes to an emergency room of a Montana hospital in the early hours of the morning with a severe asthma attack. The ER physician, nearing the end of a very busy 24-hour shift, sees the little girl. After evaluating the situation, the physician writes the order for an aerosol treatment with 3ml of Albuteral. At this point it's up to the respiratory care practitioner to recognize a decimal point is missing from the order and to contact the physician for a correct dosage order.

Currently with the unregulated practice of respiratory care in Montana. Someone with little or no formal training may be responsible for making decisions concerning medication errors.

The above is not a far fetched scenario. Medication errors happen in Montana hospitals. Hopefully someone well trained points them all out before a Montanan needlessly suffers from incompetence.

WELFARE

The attached report is from a study by the Respiratory Care Department of Missoula Community Medical Center. It details the number of inappropriate aerosol treatment or and the cost associated with providing those treatments.

North Dakota Blue Cross Study

In 1985 Marlene Moderow, R.N., a medical review field auditor for Blue Cross of North Dakota looked at the cost per day for respiratory services delivered by the educated and the uneducated provider. She found at two facilities the cost to be \$7.04 per day for educated providers and \$22.76 per day for uneducated providers, at the other hospital costs were \$12.50 per day for educated and \$20.87 for uneducated.

Ms. Moderow writes, "It has become apparent from audits completed that the cost and usage of respiratory services is a greater section of the total bill when services are delivered by the uneducated individual. Without the proper education and/or background, the services cannot be supervised properly, nor would symptomology of the patient be conferred correctly to the physician. Without this expertise, services as a rule are not discontinued timely or changed according to the condition of the patient."

Inappropriate therapy goes on in all the hospitals of Montana. The point being made here is that when competent respiratory care practitioners, who keep current on the appropriate criteria for various therapies, and work to inform their local physicians about these issues, help reduce the cost of health care to all Montanans, by not paying for needless therapies. The cost of needless therapies are reflected in every insurance premium the people of Montana pay. Simply put, the more money spent down the drain the more we pay.

How will Licensing protect the public beyond means presently available?

Attached is the standard from the Joint Committee on Accreditation of Hospitals manual for Respiratory Care Services. The standards RP.1.6.1, and RP.1.7 are what protect the public from incompetent respiratory care practitioners.

These standards leave open the possibility for facilities in Montana to hire people with little or no experience to be respiratory care practitioners.

Standard RP.1.6.1 states a Technical Director should be registered or certified by the NBRT or have the documented equivalent education, training, and/or experience. The question arises: If someone has the equivalent education, training, and experience then why can't they pass the NBRT exam? Also who is to determine what is equivalent education, training and experience?

The same can be said for standard RP.1.7. Also the standards do not deal with continuing education requirements. Currently there are none.

Licensing respiratory care practitioners will provide specific requirements and continuing education standards that must be met by respiratory care practitioners in Montana leaving nothing for others to interpretate.

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Schering—Con

Store between 15° and 30°C (59° and 86°F). Shake well before using.

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Revised 2/86

Shown in Product Identification Section, page 429

PROVENTIL®

brand of albuterol sulfate
Solution for Inhalation 0.5%*
Solution for Inhalation 0.083%*
(*Potency expressed as albuterol)

DESCRIPTION

PROVENTIL, brand of albuterol sulfate, Solution for Inhalation, is a relatively selective beta₂-adrenergic bronchodilator (see CLINICAL PHARMACOLOGY section below). Albuterol sulfate has the chemical name α^1 -(tert-Butylamino) methyl-4-hydroxy-m-xylene- α,α' -diol sulfate (2:1) (salt). Albuterol sulfate has a molecular weight of 576.7 and the empirical formula $(C_{13}H_{21}NO_3)_2 \cdot H_2SO_4$. Albuterol sulfate is a white crystalline powder, soluble in water and slightly soluble in ethanol.

The international generic name for albuterol base is salbutamol.

PROVENTIL Solution for Inhalation is available in two concentrations. The 0.5% solution is in concentrated form. Dilute 0.5 ml of the solution to 3 ml with normal saline solution prior to administration. The 0.083% solution requires no dilution prior to administration. Each ml of PROVENTIL Solution for Inhalation (0.5%) contains 5 mg of albuterol (as 6.0 mg of albuterol sulfate) in an aqueous solution containing benzalkonium chloride; sulfuric acid is used to adjust the pH between 3 and 5. PROVENTIL Solution for Inhalation (0.5%) contains no sulfiting agents. It is supplied in 20 ml bottles.

Each ml of PROVENTIL Solution for Inhalation (0.083%) contains 0.83 mg of albuterol (as 1.0 mg of albuterol sulfate) in an isotonic aqueous solution containing sodium chloride and benzalkonium chloride; sulfuric acid is used to adjust the pH between 3 and 5. PROVENTIL Solution for Inhalation (0.083%) contains no sulfiting agents. It is supplied in 3 ml bottles for unit-dose dispensing.

PROVENTIL Solution for Inhalation is a clear, colorless to light yellow solution.

CLINICAL PHARMACOLOGY

The prime action of beta-adrenergic drugs is to stimulate adenyl cyclase, the enzyme which catalyzes the formation of cyclic-3', 5'-adenosine monophosphate (cyclic AMP) from adenosine triphosphate (ATP). The cyclic AMP thus formed mediates the cellular responses. *In vitro* studies and *in vivo* pharmacologic studies have demonstrated that albuterol has a preferential effect on beta₂-adrenergic receptors compared with isoproterenol. While it is recognized that beta₂-adrenergic receptors are the predominant receptors in bronchial smooth muscle, recent data indicate that 10 to 50% of the beta receptors in the human heart may be beta₂ receptors. The precise function of these receptors, however, is not yet established. Albuterol has been shown in most controlled clinical trials to have more effect on the respiratory tract, in the form of bronchial smooth muscle relaxation, than isoproterenol at comparable doses while producing fewer cardiovascular effects. Controlled clinical studies and other clinical experience have shown that inhaled albuterol, like other beta-adrenergic agonist drugs, can produce a significant cardiovascular effect in some patients, as measured by pulse rate, blood pressure, symptoms, and/or ECG changes.

Albuterol is longer acting than isoproterenol in most patients by any route of administration because it is not a substrate for the cellular uptake processes for catecholamines nor for catechol-O-methyl transferase.

Studies in asthmatic patients have shown that less than 20% of a single albuterol dose was absorbed following either IPPB or nebulizer administration; the remaining amount was recovered from the nebulizer and apparatus and expired air. Most of the absorbed dose was recovered in the urine 24 hours after drug administration. Following a 3.0 mg dose of nebulized albuterol, the maximum albuterol plasma level at 0.5 hours was 2.1 ng/ml (range 1.4 to 3.2 ng/ml). There was a significant dose-related response in FEV₁ and peak flow rate (PFR). It has been demonstrated that following oral administration of 4 mg albuterol, the elimination half-life was five to six hours.

Animal studies show that albuterol does not pass the blood-brain barrier. Recent studies in laboratory animals (minipigs, rodents, and dogs) recorded the occurrence of cardiac arrhythmias and sudden death (with histologic evidence of myocardial necrosis) when beta-agonists and methylxanthines were administered concurrently. The significance of these findings when applied to humans is currently unknown.

In controlled clinical trials, most patients exhibited an onset of improvement in pulmonary function within 5 minutes as determined by FEV₁. FEV₁ measurements also showed that the maximum average improvement in pulmonary function usually occurred at approximately 1 hour following inhalation of 2.5 mg of albuterol by compressor-nebulizer, and remained close to peak for 2 hours. Clinically significant improvement in pulmonary function (defined as maintenance of a 15% or more increase in FEV₁ over baseline values) continued for 3 to 4 hours in most patients and in some patients continued up to 6 hours.

In repetitive dose studies, continued effectiveness was demonstrated throughout the three-month period of treatment in some patients.

INDICATIONS AND USAGE

PROVENTIL Solution for Inhalation is indicated for the relief of bronchospasm in patients with reversible obstructive airway disease and acute attacks of bronchospasm.

CONTRAINDICATIONS

PROVENTIL Solution for Inhalation is contraindicated in patients with a history of hypersensitivity to any of its components.

WARNINGS

As with other inhaled beta-adrenergic agonists, PROVENTIL Solution for Inhalation can produce paradoxical bronchospasm, which can be life threatening. If it occurs, the preparation should be discontinued immediately and alternative therapy instituted.

Fatalities have been reported in association with excessive use of inhaled sympathomimetic drugs and with the home use of sympathomimetic nebulizers. It is, therefore, essential that the physician instruct the patient in the need for further evaluation if his/her asthma becomes worse. In individual patients, any beta₂-adrenergic agonist, including albuterol solution for inhalation, may have a clinically significant cardiac effect.

Immediate hypersensitivity reactions may occur after administration of albuterol as demonstrated by rare cases of urticaria, angioedema, rash, bronchospasm, and oropharyngeal edema.

PRECAUTIONS

General: Albuterol, as with all sympathomimetic amines, should be used with caution in patients with cardiovascular disorders, especially coronary insufficiency, cardiac arrhythmias and hypertension; in patients with convulsive disorders, hyperthyroidism or diabetes mellitus, and in patients who are unusually responsive to sympathomimetic amines. Large doses of intravenous albuterol have been reported to aggravate preexisting diabetes mellitus and ketoacidosis. Additionally, beta-agonists, including albuterol, when given intravenously may cause a decrease in serum potassium, possibly through intracellular shunting. The decrease is usually transient, not requiring supplementation. The relevance of these observations to the use of PROVENTIL Solution for Inhalation is unknown.

Information for Patients: The action of PROVENTIL Solution for Inhalation may last up to six hours and therefore it should not be used more frequently than recommended. Do not increase the dose or frequency of medication without medical consultation. If symptoms get worse, medical consultation should be sought promptly. While taking PROVENTIL Solution for Inhalation, other anti-asthma medicines should not be used unless prescribed.

See illustrated "Patient's Instructions for Use."

Drug Interactions: Other sympathomimetic aerosol bronchodilators or epinephrine should not be used concomitantly with albuterol.

Albuterol should be administered with extreme caution to patients being treated with monoamine oxidase inhibitors or tricyclic antidepressants, since the action of albuterol on the vascular system may be potentiated.

Beta-receptor blocking agents and albuterol inhibit the effect of each other.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: Albuterol sulfate, like other agents in its class, caused a significant dose-related increase in the incidence of benign leiomyomas of the mesovarium in a 2-year study in the rat, at oral doses corresponding to 10, 50 and 250 times the maximum human nebulizer dose. In another study, this effect was blocked by the coadministration of propranolol. The relevance of these findings to humans is not known. An 18-month study in mice and a lifetime study in hamsters revealed no evidence of tumorigenicity. Studies with albuterol revealed no evidence of mutagenesis. Reproduction studies in rats revealed no evidence of impaired fertility.

Teratogenic Effects—Pregnancy Category C: Albuterol has been shown to be teratogenic in mice when given subcutaneously in doses corresponding to the human nebulization dose. There are no adequate and well-controlled studies in pregnant women. Albuterol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. A reproduction study in CD-1 mice with albuterol (0.025, 0.25 and 2.5 mg/kg subcutaneously, corresponding to 0.1, 1, and 12.5 times the maximum human ne-

bulization dose, respectively) showed cleft palates of 111 (4.5%) of fetuses at 0.25 mg/kg, (9.3%) of fetuses at 2.5 mg/kg. None were observed at 0.025 mg/kg. Cleft palate also occurred in 22 fetuses treated with 2.5 mg/kg isoproterenol. A reproduction study in Stride Dutch craniocochleia in 7 of 19 (37%) of fetuses at dosing to 250 times the maximum human dose.

Labor and Delivery: Oral albuterol has been reported to cause preterm labor in some reports. There are controlled studies which demonstrate that term labor or prevent labor at term. There of PROVENTIL Solution for Inhalation is not patients when given for relief of bronchospasm to avoid interference with uterine contractility. **Nursing Mothers:** It is not known whether excreted in human milk. Because of the potential shown for albuterol in some animal studies, should be made whether to discontinue nursing or to continue the drug, taking into account the benefits to the mother.

Pediatric Use: Safety and effectiveness of PROVENTIL Solution for Inhalation in children below the age of 12 have not been established.

ADVERSE REACTIONS

The results of clinical trials with PROVENTIL Solution for Inhalation in 135 patients showed the following which were considered probably or possibly related to the drug: Central Nervous System: tremors (20%), nervousness (4%), headache (3%), insomnia (3%), Gastrointestinal: nausea (4%), dyspepsia (4%), Ear, Nose and Throat: pharyngitis (<1%) (1%).

Cardiovascular: tachycardia (1%), hyperreflexia (1%), **Respiratory:** bronchospasm (8%), cough (4%), wheezing (1%).

No clinically relevant laboratory abnormalities were observed. PROVENTIL Solution for Inhalation administered in these studies.

In comparing the adverse reactions reported in patients treated with PROVENTIL Solution for Inhalation with those of patients treated with isoproterenol in clinical trials of three months, the following moderate to severe reactions, as judged by the investigators, were observed. No mild reactions were observed.

Percent Incidence of Moderate To Severe Reactions

Reaction	Albuterol N=65
Central Nervous System	
Tremors	10.7%
Headache	3.1%
Insomnia	3.1%
Cardiovascular	
Hypertension	3.1%
Arrhythmias	0%
Palpitation	0%
Respiratory	
Bronchospasm	15.4%
Cough	3.1%
Brachitis	1.5%
Wheezing	1.5%
Sputum Increase	1.5%
Dyspnea	1.5%
Gastrointestinal	
Nausea	3.1%
Dyspepsia	1.5%
Systemic	
Malaise	1.5%

* In most cases of bronchospasm, this was used to describe exacerbations in the underlying disease.

** The finding of no arrhythmias and no other adverse effects in this clinical trial is interpreted as indicating that these effects do not occur after the administration of PROVENTIL Solution for Inhalation.

Rare cases of urticaria, angioedema, rash and oropharyngeal edema have been reported with inhaled albuterol.

OVERDOSAGE

Manifestations of overdosage may include tachycardia, hypertension, and exaggerated effects listed in ADVERSE REACTIONS. The oral LD₅₀ in rats and mice was 1.5 mg/kg. The inhalational LD₅₀ could not be determined. There is insufficient evidence to determine the clinical significance of overdosage of PROVENTIL Solution for Inhalation.

DOSAGE AND ADMINISTRATION

The usual dosage for adults and children is 2.5 mg of albuterol administered 3 to 4 times daily. More frequent administration or higher doses are not recommended. To administer 2.5 mg of albuterol, dilute 0.5 ml of the 0.5% solution for inhalation with 2.5 ml of normal saline solution.

January 30, 1985

Mr. Gary Brown
Respiratory Therapy
St. Luke's Hospitals
Fargo, North Dakota 58122

RESPIRATORY THERAPY SERVICES

Respiratory therapy services in the state of North Dakota have been observed in the audit process and also in the individual group studies of cost per hospital day.

It is apparent by these studies that respiratory therapy in some areas has been used excessively with possibly little professional expertise to monitor or deliver these services. Without the proper education and/or background, the services cannot be supervised properly, nor would symptomology of the patient be conferred correctly to the physician. Without this expertise, services as a rule are not discontinued timely or changed according to the condition of the patient.

It has become apparent from audits completed that the cost and usage of respiratory services is a greater section of the total bill when the services are delivered by the uneducated individual.

Actual statistics for a past year for a particular bed-sized hospital were \$7.04 per day for educated providers and \$22.76 for the uneducated provider. Another bed-sized hospital statistic was \$12.50 for the educated provider while \$20.87 for the uneducated provider.

It appears the proper training and education are vital for the proper delivery of respiratory services while keeping the safety and well-being of the patient in mind as well as the total dollar spent for this service.

Marlene Moderow, R.N.

MARLENE MODEROW, R.N.
Medical Review Field Auditor

3/18/91 HB 620

Circle One

RP.1.6.1 When the scope of services warrants it, respiratory care services are supervised by a technical director who is registered or certified by the National Board for Respiratory Therapy, Inc, or who has the documented equivalent education, training, and/or experience.

① 2 3 4 5 NA

RP.1.6.1.1 The technical director's duties include responsibility for assuring

RP.1.6.1.1.1 the supervision of respiratory personnel in the performance of respiratory therapy and any designated related laboratory procedures;

① 2 3 4 5 NA

RP.1.6.1.1.2 the care, maintenance, and disinfection or sterilization of all ventilatory equipment, accessories, and, as required, supplies; and

① 2 3 4 5 NA

RP.1.6.1.1.3 the maintenance of appropriate records and reports.

① 2 3 4 5 NA

RP.1.6.1.2 Additional responsibilities may be designated to the technical director by the physician providing medical direction for the respiratory care services.

① 2 3 4 5 NA

RP.1.7 Other qualified respiratory care personnel provide respiratory care services commensurate with their documented training, experience, and competence.*

① 2 3 4 5 NA

RP.1.7.1 Such personnel may include

RP.1.7.1.1 registered respiratory therapists or certified respiratory therapy technicians, or individuals with the documented equivalent in education, training, and/or experience;

① 2 3 4 5 NA

RP.1.7.1.2 qualified cardiopulmonary technologists; and

1 2 3 4 5 NA

RP.1.7.1.3 appropriately trained licensed nurses.

1 2 3 4 5 NA

RP.1.8 Personnel who provide respiratory care services comply with all applicable law and regulation.*

1 2 3 4 5 NA

RP.1.9 The training of respiratory therapy students is carried out only in programs accredited by the appropriate professional educational organization.

① 2 3 4 5 NA

RP.1.9.1 Students are directly supervised by a qualified respiratory therapist or technician, particularly when engaged in patient care activities.

1 2 3 4 5 NA

RP.1.9.2 When the hospital provides clinical facilities for the education and training provided by an outside program, the respective roles and responsibilities of the respiratory care department/service and the outside educational program are defined.

1 2 3 4 5 NA

PROCEDURE	DESCRIPTION OF THERAPY	INDICATIONS FOR THERAPY	HAZARDS/COMPLICATIONS
Endotracheal Intubation	Emergency or elective placement of endotracheal tube into the trachea or respiratory tract in order to provide an airway and/or ventilate a patient, includes infants, children, adults.	Cardiac or respiratory arrest. Any other event whereby patients can no longer breathe on their own or require possible assisted ventilation. Routinely done for long operative procedures.	1. Improper placement of tube resulting in asphyxiation, hypoxia (lack of oxygen to brain and other vital organs), carbon dioxide narcosis. 2. Damage and/or paralysis of vocal cords. 3. Rupture and hemorrhage to esophagus and/or trachea. 4. Atelectasis--collapsed lung. 5. Pneumothorax (lung collapse). 6. Dental fractures. 7. Aspiration of blood, stomach contents. 8. Infection.
Suctioning	A procedure necessary for removal of secretions from endotracheal, tracheostomy tubes or the respiratory tract directly to maintain a patent, functioning airway.	Patients that have endotracheal /tracheostomy tubes in place. Patients unable to cough to remove secretions. Newborns or infants with pulmonary distress.	1. Sudden death syndrome secondary to vagal stimulation. 2. Cardiac arrest or standstill. 3. Cardiac arrhythmias. 4. Hypoxia--oxygen lack to brain and vital organs. 5. Bleeding/hemorrhage, damage to trachea. 6. Infection.

Exhibit # 1
3/18/91 HB 620

PROCEDURE	DESCRIPTION OF THERAPY	INDICATIONS FOR THERAPY	HAZARDS/COMPLICATIONS
Arterial Blood Gas Sampling	A procedure whereby a therapist inserts a needle into an artery (radial, brachial or femoral) to obtain arterial blood for analysis. Determines the need for oxygen therapy and amounts of oxygen and carbon dioxide in blood. Determines metabolic status (A/B).	To determine cardio-respiratory status of patients: Including patients with-- Shortness of breath Mechanically ventilated patients Kidney failure Trauma victims Diabetic crisis Cardiac/respiratory arrest--pre-arrest state Drug overdose Post-operative patients	1. Damage or destruction of artery resulting ultimately in amputation of affected limb 2. Hematoma/hemorrhage. 3. Damage/paralysis of nerve adjacent to sampling site. 4. Infection. 5. Intense pain due to poor technique. 6. Air embolus.
C.P.R. - Cardio-Pulmonary Resuscitation	A life saving procedure requiring immediate and appropriate assessment and response to a patient with cardiac or respiratory arrest. Includes providing airway and artificial ventilation along with external cardiac compressions.	Cardiac or respiratory arrest. Newborn-premature infants requiring resuscitation measures at birth. Airway obstruction-choaking victims.	1. Improper technique can result in death. 2. Fractured ribs, sternum 3. Liver lacerations. 4. Gastric distention (air in stomach) with resultant aspiration/pneumonitis. 5. Fractured necks in infants/children. 6. Pneumothorax--burst/collapsed lung in infants/children.

PROCEDURE	DESCRIPTION OF THERAPY	INDICATIONS FOR THERAPY	HAZARDS/COMPLICATIONS
Oxygen Therapy	Oxygen is a drug administered by a mask, nasal cannula, tent (infants/children) or positive-pressure demand valves.	Hypoxemia -- low oxygen content in the blood. Examples of patients requiring oxygen are: Chronic lung patients Emphysema Pneumonia Asthma Bronchitis Cystic Fibrosis Cardiac patients *There are approximately 8,000 patients in New Jersey <u>AT HOME</u> on oxygen.	1. Oxygen toxicity--results in damage to lung tissue. 2. Blindness in infants. 3. Can eliminate the drive to breathe in some patients (COP 4. Infection.
Postural Drainage Chest Percussion	A mode of therapy requiring proper positioning of patient for safe/effective drainage of lung segments.	Any disease state requiring removal of mucous secretions from lungs. Cystic Fibrosis Pneumonia Bronchitis Asthma Emphysema	1. Can increase intracranial pressure--patient must be properly monitored--especially infant may cause intracranial bleed 2. Spread of infection to another lung segment. 3. Aspiration. 4. Pneumothorax.

PROCEDURE	DESCRIPTION OF THERAPY	INDICATIONS FOR THERAPY	HAZARDS/COMPLICATIONS
Aerosol therapy	A mode of therapy to dispense medication directly to respiratory tract. Given by mask or hand-held device. Can be given with compressed air or oxygen to infants, children, adults. Drugs used include: Sympathomimetic agents (bronchodilators) Antibiotics Antifungal agents Mucolytics	Patients with shortness of breath (SOB) due to: Asthma Emphysema Chronic Lung Disease Cystic Fibrosis Tuberculosis Pneumonia Bronchitis Retained Secretions (mucous) Inhalation burns (heat, smoke) Chemical inhalation	1. Irregular heart rates/ rhythms. Tachycardias/ arrhythmias leading to cardiac arrest. 2. Effects blood pressure. 3. Can effect central nervous system causing tremors, agitation, insomnia. 4. Nausea. 5. Overhydration--fluid overload with resultant heart failure from excessive use of ultra-sonic therapy. 6. Allergic reactions to medications. 7. Infection from improperly dispersed medication. 8. Inherent problems from over-use of oxygen (see Oxygen Therapy). 9. Can aggravate asthmatic attack if improperly administered.
IPPB therapy	A mode of therapy to disperse medication directly to respiratory tract. Similar to aerosol therapy, but IPPB (Intermittent Positive Pressure Breathing) is administered under pressure to the lungs. Can be used with compressed air or oxygen to children, adults. Drugs include: Sympathomimetic agents	Patients with S.O.B. See Aerosol Therapy (above)	Same hazards as aerosol therapy and 1. Pneumothorax-- air which does not belong in chest cavity requiring emergency insertion of chest tube to prevent cardio-respiratory arrest. 2. Decreases cardiac output. Can result in arrest. 3. Oxygen complications.

PROCEDURE	DESCRIPTION OF THERAPY	INDICATIONS FOR THERAPY	HAZARDS/COMPLICATIONS
Mechanical Ventilation Respirators	A life support device-machine to which the patient is directly attached via endotracheal/tracheostomy tube for the purpose of providing ventilation (breathing) for the patient.	Any condition affecting the ability of the person to breathe thereby maintaining proper oxygen, carbon dioxide levels, adequate metabolic status to maintain life. Respiratory/Cardiac Failure Trauma/Shock Post Operative complications Anesthetic Overdose Drug Overdose Ethanol poisoning (alcohol overdose) Foreign Body Obstruction Premature Infants	Due to the fact that once a patient is placed on a life support system/ventilator, the ultimate hazard secondary to mechanical failure, poor monitoring of patient is, <u>death</u>, permanent brain or vital organ destruction. Some of the major medical emergencies that arise are: Deceased cardiac output Deceased blood pressure Deceased urinary output Barotrauma-pneumothorax Collapsed lung Oxygen toxicity Severe metabolic imbalances Severe electrolyte imbalances Infection Tracheal hemorrhage

SUPPORTING LITERATURE

AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Statement advocating respiratory therapy licensure.

HOSPITAL & HEALTH SERVICES ADMINISTRATION

Spring 1990

Study demonstrating that rural hospitals with allied health services that include qualified respiratory care services are less likely to risk closure.

AMERICAN ENTERPRISE FOR PUBLIC POLICY RESEARCH

Study of occupational licensure and regulation demonstrating that licensure has no significant effect on earnings and that licensed occupations demonstrate a higher retention rate than those without licensure.

BLUE CROSS OF NORTH DAKOTA

Letter from Blue Cross of North Dakota demonstrating increased patient care costs when respiratory care is provided by uneducated providers.

Statement Regarding Respiratory Therapy Licensure

ASA AMERICAN SOCIETY
OF ANESTHESIOLOGISTS

STATEMENT REGARDING RESPIRATORY THERAPY LICENSURE

(Approved by House of Delegates on October 16, 1985)

Anesthesiology is the practice of medicine which, in addition to the personal performance or medical direction of anesthesia care, includes clinical management of problems in Respiratory Care. The provision of Respiratory Care involves the participation of non-physicians, typically Respiratory Therapists, working under the medical direction of an Anesthesiologist or other qualified physicians. The American Society of Anesthesiologists, believing that all personnel involved in providing direct patient care must possess appropriate qualifications and competence to perform the aspects of the patient's care in which they are involved, has enthusiastically supported the efforts of the Joint Review Committee for Respiratory Therapy Education and the National Board for Respiratory Care to provide accredited educational programs and national credentials for Respiratory Therapists.

Increasingly, state legislatures are considering legal credentialing for qualified non-physician Respiratory Care Practitioners (Respiratory Therapists). Given the adequacy of non-governmental credentialing mechanisms, the Society does not support Respiratory Care licensure bills which would define the scope of practice of Respiratory Therapists and establish the qualifications of persons entitled to participate in Respiratory Care, unless no other method of credentialing appears viable and unless the bill contains adequate provisions for medical direction and educational requirements.

Any legislation relating to the credentialing of Respiratory Therapists, whether or not providing for formal licensure, should in any event be consistent with the following principles: 1) The practice of Respiratory Care by non-physicians should be permitted only under the medical direction of an Anesthesiologist or other qualified physician and 2) Minimum standards of education, training and competency should be consistent and compatible with existing national standards of non-governmental credentialing in Respiratory Care.

When called upon to deal with proposed legislation involving the credentialing of Respiratory Therapists, Component Societies of this Society are urged to assure through appropriate testimony and legislative advocacy that any proposed credentialing statute, even involving licensure, is in accordance with the principles stated above.

The American Society of Anesthesiologists

515 Busse Highway / Park Ridge, IL 60068 / (312) 825-5586

January 30, 1985

Mr. Gary Brown
Respiratory Therapy
St. Luke's Hospitals
Fargo, North Dakota 58122

RESPIRATORY THERAPY SERVICES

Respiratory therapy services in the state of North Dakota have been observed in the audit process and also in the individual group studies of cost per hospital day.

It is apparent by these studies that respiratory therapy in some areas has been used excessively with possibly little professional expertise to monitor or deliver these services. Without the proper education and/or background, the services cannot be supervised properly, nor would symptomology of the patient be conferred correctly to the physician. Without this expertise, services as a rule are not discontinued timely or changed according to the condition of the patient.

It has become apparent from audits completed that the cost and usage of respiratory services is a greater section of the total bill when the services are delivered by the uneducated individual.

Actual statistics for a past year for a particular bed-sized hospital were \$7.04 per day for educated providers and \$22.76 for the uneducated provider. Another bed-sized hospital statistic was \$12.50 for the educated provider while \$20.87 for the uneducated provider.

It appears the proper training and education are vital for the proper delivery of respiratory services while keeping the safety and well-being of the patient in mind as well as the total dollar spent for this service.

Marlene Moderow, R.N.

MARLENE MODEROW, R.N.
Medical Review Field Auditor

Rural Hospital Survival: An Analysis of Facilities and Services Correlated with Risk of Closure

Ross M. Mullner is Associate Professor in Health Resources Management, School of Public Health, University of Illinois, Chicago. Robert J. Rydman is Associate Director for Research and Development, and David G. White is Research Associate, Center for Health Services Research, School of Public Health, University of Illinois, Chicago.

Summary

To test whether the facilities and services offered by rural hospitals can put them at risk of closure or protect against it, this study compares U.S. rural community hospitals that closed during the period 1980–1987, with a matched set of hospitals that remained open. Utilizing epidemiologic matched case-control methods and controlling for type of ownership, we found that (1) physical therapy, respiratory therapy, intensive care unit, computed tomography scanner, hospital auxiliary, and diagnostic radioisotope were negatively correlated with closure (i.e., had a protective effect); (2) the facilities and services correlated with risk of closure differed significantly between the pre-PPS (1980–1983) and post-PPS (1984–1987) periods; and (3) the presence of a skilled nursing or other long-term care unit was a significant risk factor during the period 1984–1987. Implications of these findings for hospital survival strategies and rural health care delivery under PPS are discussed.

Address correspondence and requests for reprints to Ross M. Mullner, Ph.D., 10301 S. Kostner, Oak Lawn, IL 60453.

From:
Rottenborg, S.
Occupational Licensure and
Regulation, Washington, D.C.
American Enterprise Institute
for Public Policy Research, 1980

FROM:
ROTTENBORG, S.
OCCUPATIONAL LICENSURE AND
REGULATION
AMERICAN ENTERPRISE INSTITUTE
FOR PUBLIC POLICY RESEARCH
WASHINGTON D.C.

Has Occupational Licensing Reduced Geographical Mobility and Raised Earnings?

B. Peter Pashigian

In principle, there are several ways to determine the effects of occupational licensing on earnings and mobility. It is seldom possible to compare licensed with unlicensed states (since licensed occupations tend to be licensed in all or most states), but one can compare states that apply stringent standards in licensing an occupation with states that enforce less stringent standards. This popular method of measuring the effects of licensing has distinct limitations when state differences in licensing stringency are difficult to measure. An alternative approach would be to compare an occupation before and after the advent of licensing. Unfortunately, many occupations were licensed before the second decade of the twentieth century, and the dearth of information often precludes a before-and-after study.¹ Given these obstacles, one is forced to consider a third alternative. Licensed occupations may be compared with unlicensed occupations to determine how earnings and mobility are affected by occupational licensing. While this approach also suffers from several drawbacks (one of which is the comparability of occupations), it does have the merit of comparing extremes, licensing and no licensing, rather than some licensing versus more licensing. The objective of this kind of study would be to determine if a "representative" licensed occupation differs in important ways from a "representative" unlicensed occupation.

This is the approach adopted here. One hundred and fifty-seven occupations, some licensed and many unlicensed, are analyzed to determine if members of licensed occupations (1) are less likely to move across state boundaries, (2) are less likely to move from one market to another within the state, (3) are less likely to change occupations, and (4) report higher earnings.

NOTE: The author acknowledges the helpful comments by the discussants at the conference, Stuart Dorsey and Janice Madlen, and by participants in the Justice Workshop and the Workshop in Applications of Economics at the University of Chicago.
¹ Thomas G. Moore, "The Purpose of Licensing," *Journal of Law and Economics* (1961), pp. 93-117.

(Exhibit 1A)
3/18/91
HB 620

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 18 day of March, 1991.

Name: Nicholas WALTER M.D.

Address: 2921 W Macdonell Dr
Bullseye MT 59102

Telephone Number: 406 652 6594

Representing whom?

SELF + mt Soc Resp Care

Appearing on which proposal?

Bill 620 Licensing Resp Care Practitioners

Do you: Support? ✓ Amend? Oppose?

Comments:

licensing important to ensure
quality of care delivered to
hospitalized patients

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

SENATE HEALTH & WELFARE

EXHIBIT NO. 2

DATE 3/18

H BILL NO. 620.

Amendment to HB 620

Prepared by Mary McCue for Montana Society of Respiratory Care

1. Page 6, line 6.

Following: "board"

Insert: ", except that one member of the board need not be an attorney licensed to practice law in this state"

THE RESPIRATORY CENTER



RONALD E. BURNAM, M.D., F.C.C.P.
FREDERICK W. KAHN, M.D., F.C.C.P.
THOMAS P. THIGPEN, M.D., F.C.C.P.

EXHIBIT NO. 2

DATE 3/18

BILL NO. 620

February 8, 1991

Montana State Legislature
State Capitol
Helena, MT 59624

To Whom It May Concern:

I am writing you in regards to the proposed respiratory care legislature act that is before the current session of the legislature.

I am a practicing physician in Billings and a respiratory specialist. I would like to go on record as being a firm supporter of this type of legislative act.

Respiratory care has expanded rapidly over the past several years with very sophisticated modalities now available both as inpatient and outpatient possibilities. Because of the sophistication of these services that need to be provided I think that it is adamant that there be some mechanism to oversee the training and supervision of the individuals who provide these various services. It seems to me that the way that this bill is proposed it is obvious that a great deal of thought has been put into this and that the public can be assured that people who are providing services are in fact qualified.

Once again, I think this is a good thing to have and I would very much encourage your support.

Sincerely,

Thomas P. Thigpen M.D.

Thomas P. Thigpen, M.D.

TPT/bjs

GREAT FALLS CLINIC

1400 TWENTY-NINTH STREET SOUTH
P.O. BOX 5012
GREAT FALLS, MONTANA 59403-5012
PHONE (406) 454-2171
FAX (406) 454-0455

February 19, 1991

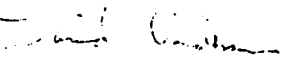
To whom it may concern:

This letter is concerning the respiratory therapy licensure bill. I very strongly favor this bill since it would standardize respiratory therapy in the state of Montana. Since Montana has two schools of respiratory therapy, namely in Great Falls and Missoula, almost every hospital in this state now has access to properly trained people in respiratory therapy, that is either certified respiratory therapy technicians or registered respiratory therapists. Therefore there should be no hardship caused by a requirement that only qualified people give respiratory therapy in hospitals in Montana.

I have been medical director of the respiratory care service at Montana Deaconess Medical Center for about 13 years and am well aware of the quality of service rendered by people properly trained in respiratory therapy compared to people who receive on-the-job training. When I took over as medical director of the respiratory care service at Deaconess, most of the people giving respiratory therapy treatments received on-the-job training. As a consequence I saw many mistakes made and also very little in the way of patient education being performed. Once the policy changed to where Montana Deaconess hired only certified or registry-eligible people or encouraged people who had received on-the-job training to get their certification or registry, there was a significant improvement in the quality of care. Licensure of respiratory therapists would also allow respiratory therapists to render services on an out-patient basis to government-financed medical care programs such as Medicaid, welfare, etc. This would significantly improve the quality of care that these people receive and I suspect in many cases would initiate respiratory care treatment early enough such that later hospital admissions for an untreated respiratory problem would not be necessary.

For these reasons, therefore, I strongly endorse a bill that would ally licensure of respiratory therapy practitioners in the state of Montana.

Best wishes,


David E. Anderson, M. D.

DEA/mns

INTERNAL MEDICINE
S.P. AKRE, M.D.
Rheumatology
F.J. ALLAIRE, M.D.
D.E. ANDERSON, M.D.
R.D. BLEVINS, M.D.
Pulmonary Disease
G.A. BUFFINGTON, M.D.
Nephrology
S.J. EFFERTZ, M.D.
Rheumatology
J.D. EIDSON, M.D.
K.A. GUTER, M.D.
Oncology
P.A. KREZOWSKI, M.D.
Endocrinology
T.J. LENZ, M.D.
B.L. MAYNARD, M.D.
W.N. MILLER, M.D.
Gastroenterology
T.W. ROSENBAUM, M.D.
Nephrology
G.D. SPENCER, M.D.
Gastroenterology
J.D. WATSON, M.D.
Cardiology
OBSTETRICS AND GYNECOLOGY
C.J. BELL, DO.
P.L. BURLEIGH, M.D.
F.J. HANDWERK, M.D.
R.J. McCLURE, M.D.
G.K. PHILLIPS, M.D.
S.M. WARD, R.N., C
Certified Nurse Practitioner
NEURO-SCIENCES
D.E. ENGSTROM, M.D.
Psychiatry
W.H. LABUNETZ, M.D.
Neurology-EEG
E.E. SHUBAT, Ph.D.
Psychology
T.J. KRAJACICH, Ph.D.
Psychology
OPHTHALMOLOGY
A.A. JORDAN, JR., M.D.
ORTHOPAEDIC SURGERY
P.A. SUAREZ, M.D.
PEDIATRICS
J.M. EICHNER, M.D.
N.C. GERRITY, M.D.
J.R. HALSETH, M.D.
J.P. HINZ, M.D.
C.G. MATELICH, M.D.
N.J. MAYNARD, M.D.
J.G. ROSENFELD, M.D.
D.P. RUGGERIE, DO.
Pediatric Cardiology
SURGERY
W.P. HORST, M.D.
Urology
R.E. LAURITZEN, M.D.
General and Vascular
J.E. MUNGAS, M.D.
Vascular and General
M.B. ORCUTT, M.D.
General and Vascular
J.A. SCHVANEVELDT, M.D.
Ear, Nose & Throat
L.M. TAYLOR, M.D.
General and Thoracic
W.C. VASHAW, M.D.
General and Vascular
FAMILY PRACTICE CENTER
J.A. ROSS, M.D.
J.W. SPEER, M.D.
T.C. WEILL, M.D.
1220 Central Avenue
771-0090
IMMEDIATE CARE CENTER
D.R. ENGBRECHT, M.D.
T.J. SWEENEY, M.D.
1220 Central Avenue
771-0000
ADMINISTRATION
W.D. TAYLOR
M.D. MISSIMER
J.C. KINHA

AMERICAN LUNG ASSOCIATION OF MONTANA

Christmas Seal Bldg. — 825 Helena Ave.
Helena, MT 59601 — Ph. 442-6556

EARL W. THOMAS
EXECUTIVE DIRECTOR

SENATE HEALTH & WELFARE

EXHIBIT NO. 3

DATE 3/18

H BILL NO. 620

TO: PUBLIC HEALTH, WELFARE & SAFETY COMMITTEE
CHAIR: Dorothy Eck

ROOM: 410 Monday, March 18, 1991

FROM: EARL THOMAS, EXECUTIVE DIRECTOR

SUBJECT: HB620 - SPONSOR CAROLYN SQUIRES
"LICENSURE FOR RESPIRATORY CARE. ESTABLISHING A RESPIRATORY
CARE BOARD:

THE AMERICAN LUNG ASSOCIATION OF MONTANA SUPPORTS HB 620
BECAUSE WE BELIEVE IT WILL PROTECT THE PUBLIC FROM UNQUALIFIED
RESPIRATORY CARE.

THE FIELD OF RESPIRATORY CARE IS A VERY DEMANDING ONE. ONE
ONLY NEED LOOK AT THE COURSE OF STUDY AT EITHER OF MONTANA'S
TWO RESPIRATORY THERAPY SCHOOLS TO RECOGNIZE WHAT A RIGOROUS
AND SOPHISTICATED FIELD THIS IS.

RESPIRATORY CARE IS AN EXPANDING FIELD BECAUSE RESPIRATORY
ILLNESS IS ONE OF THE FASTEST RISING DISEASES IN THE UNITED
STATES AND MONTANA CONSISTENTLY RANKS IN THE TOP FIVE.

*attachment
entered*
A NATIONAL HEALTH INTERVIEW SURVEY DONE IN 1987 SHOWED THAT
PERSONS SUFFERING FROM CHRONIC BRONCHITIS, EMPHYSEMA AND ASTHMA
INCREASED 75.9% FROM 1970 to 1987. ~~THE~~ THE ATTACHED YELLOW SHEET
PROVIDES FURTHER SUPPORT ON HOW LUNG DISEASE DEATHS ARE
INCREASING.

cm
SINCE LUNG ILLNESSES ARE 75 TO 85% PREVENTABLE. WE ARE NOW
PAYING THE PRICE FOR THE 43% OF THE POPULATION WHO SMOKED IN
THE 1960'S. WE ARE PROUD TO STATE THAT MONTANA CURRENTLY
HAS ONE OF THE LOWEST SMOKING RATES IN THE COUNTRY WITH LESS
THAN 20%. HOWEVER IT WILL BE MANY YEARS BEFORE WE SEE THE
BENEFITS OF THIS.

RESPIRATORY CARE PRACTITIONERS ARE NOT ONLY IN HOSPITALS AND
CLINICS BUT ALSO IN THE PATIENTS HOMES PROVIDING CARE AND
EDUCATION.

PLEASE GIVE HB 620 A DO PASS RECOMMENATION TO INSURE THE
CONTINUED HIGH QUALITY OF RESPIRATORY CARE

OFFICE OF THE GOVERNOR
MENTAL DISABILITIES BOARD OF VISITORS



STAN STEPHENS, GOVERNOR

CAPITOL STATION

STATE OF MONTANA

(406) 444-3955
OR TOLL FREE 1-(800)-332-2272

HELENA, MONTANA 59620

March 18, 1991

Senator Dorothy Eck
Senate Public Health
State Capitol
Helena, MT 59620

SENATE HEALTH & WELFARE

EXHIBIT NO. 4

DATE 3/18

HBILL NO. 713

Madame Chair and Members of the Committee:

For the record, my name is Kelly Moore and I serve as the Director of the Board of Visitors. The Board of Visitors reviews patient care and treatment at the Center for the Aged, along with other state-run mental health facilities. The Board of Visitors supports the changes offered in House Bill 713.

The admissions process at the Center for the Aged is covered by rule-making and the admissions screening process. Key to the admission process is a mental disorder, which is defined earlier in the commitment law. The reference to "associated with the aging process" is simply not needed. A diagnosis of a mental illness is not a result of the aging process.

We urge this committee to pass HB 713.

Sincerely,

A handwritten signature in cursive script that reads "Kelly Moore".

Kelly Moore
Executive Director

SENATE HEALTH & WELFARE
EXHIBIT NO. 5
DATE 3/18
H BILL NO. 670

Some Facts About House Bill 620
Sponsored by Rep. Carolyn Squires
Licensure of Respiratory Care Practitioners

--- Will respiratory care practitioners be given an exclusive license to practice respiratory care?

No, this bill allows other health care providers who are allowed under their own scope of practice to perform respiratory care to continue to do so.

--- How many states currently license respiratory care practitioners?

31 states have some form of licensure and regulation.

--- Do present statutes guarantee quality respiratory care?
Why is licensure necessary?

Due to the legal liability of personnel departments that prevents them from providing detailed information regarding a job applicant, it is difficult for hospitals and other employers to know if a prospective respiratory care practitioner employee is competent. This allows those few incompetent practitioners to move from job to job without detection. Licensure and regulation provide a means to ensure quality respiratory care. There also presently are no mandatory continuing education requirements to ensure continuing quality respiratory care.

The Joint Commission on the Accreditation of Hospitals (JCAH) requirements that accredit hospitals has not dealt with the problem of incompetent practitioners and does not mandate continuing education.

--- Will licensure raise the cost of employing respiratory care practitioners?

No. Regarding salaries, the market dictates what respiratory care practitioners are paid, not the fact the group is licensed. As to insurance reimbursement issues, Medicare, Medicaid, and private insurance policies already provide for reimbursement of respiratory care services, for both inpatient and outpatient services. This bill does not add a new group to the list of health care providers seeking reimbursement for their services.

--- Will the respiratory care practitioners who received their training on the job and who have no formal school training be able to continue working?

Yes. The bill contains a "grandfather" provision that allows respiratory care practitioners who have worked in Montana for 12 months to be licensed without examination and without completing the education requirement. They then will have to satisfy the continuing education requirement the same as other licensees.

--- Will there be a shortage of respiratory care practitioners if practitioners are licensed?

No, there are programs at the Missoula and Great Falls vo-tech centers that graduate between 30-40 respiratory technicians each year.

--- How many respiratory care practitioners are there presently in Montana?

More than 300.

DATE: 2/18/91

COMMITTEE ON Sen. Public Health, Welfare + Safety

ibi HB 620, 635, 713, 831, 862

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One	
			Support	Oppos
Darryl Bruno	Institution	831	✓	
Edith Thomas	Amer Lung Assn	620	✓	
Felix Moore	Board of Visitors	713/862	✓	
JANE EDWARDS	MT STATE HOSPITAL	862	✓	
Michael Biggins	MT Soc. of Respiratory Care	620	✓	
Hank Hudson	Office on Aging, Gov. Office	635/713	✓	
Rich Lundy	MT SOCIETY FOR RESPIRATORY CARE	620	✓	
Nicholas Wolter	MT SOCIETY RESP Care	620	✓	
Rose Hughes	MT. Hlth Care Assn	635	✓	
John Orsman	MT CATHOLIC CONF	635	✓	
Mikes Pappas	COPM	831	✓	
Steve Brownings	MT Hosp Assn	635	✓	
Tim Owens	MT Hosp Assn	620		✓

Amendments, Discussion, and Votes:

There being no objections the amendments denoted in Exhibit #7 were adopted.

Recommendation and Vote:

Senator Pipinich moved concurrence as amended. There being no objections the motion carried.

EXECUTIVE ACTION ON HOUSE BILL 713

Motion:

Senator Pipinich moved to table the bill.

Discussion:

Senator Pipinich said after much consideration and discussion about the effect of this measure on Galen and Warm Springs, he said he is convinced it is a back door closure of these institutions. He said he did not want to kill the bill. He wanted to table it until further action.

Recommendation and Vote:

There being 6 ayes and 2 nays by Senators' Burnett and Rye, the motion carried.

EXECUTIVE ACTION ON HOUSE BILL 620

Motion:

Senator Pipinich moved adoption of the amendments denoted in Exhibit #8.

Discussion:

Tom Gomez explained the amendments by saying the sponsor and the Respiratory Care Association requested.

Amendments, Discussion, and Votes:

There being 7 ayes and 1 nay by Senator Hager, the motion carried.

Recommendation and Vote:

Senator Franklin moved concurrence as amended. There being 6 ayes and 2 nays by Senators' Burnett and Hager, the motion carried.

PUBLIC HEALTH, WELFARE
AND SAFETY

COMMITTEE

Date March 20, 19

NAME	PRESENT	ABSENT	EXCUSED
SENATOR BURNETT	X		
SENATOR FRANKLIN	X		
SENATOR HAGER	X		
SENATOR JACOBSON	X		
SENATOR PIPINICH	X		
SENATOR RYE	X		
SENATOR TOWE	X		
SENATOR ECK	X		

Each day attach to minutes.

SENATE STANDING COMMITTEE REPORT

Page 1 of 1
March 21, 1991

MR. PRESIDENT:

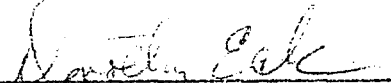
We, your committee on Public Health, Welfare, and Safety having had under consideration House Bill No. 620 (third reading copy -- blue), respectfully report that House Bill No. 620 be amended and as so amended be concurred in:

1. Page 6, line 5.

Following: "quasi-judicial board"

Insert: ", except that one member of the board need not be an attorney licensed to practice law in this state"

Signed


Dorothy Eck, Chairman

Jan 3-21-91
Amd. Coord.

SP 3-2 9:45
Sec. of Senate

610831SC.311

65

Amendments to House Bill No. 620 DATE 3/20
Third Reading Copy

BILL NO. 620.

Requested by Representative Carolyn Squires
For the Senate Public Health, Welfare, and Safety Committee

Prepared by Tom Gomez
March 20, 1991

1. Page 6, line 6.

Following: "quasi-judicial board"

Insert: ", except that one member of the board need not be an
attorney licensed to practice law in this state"

ROLL CALL VOTE

SENATE COMMITTEE PUBLIC HEALTH, WELFARE & SAFETY

Date March 20, 1991 H Bill No. 620 Time 4:57 p.m.

NAME	YES	NO
SENATOR BURNETT	X	
SENATOR FRANKLIN	X	
SENATOR HAGER		X
SENATOR JACOBSON	X	
SENATOR PIPINICH	X	
SENATOR RYE	X	
SENATOR TOWE	X	
SENATOR ECK	X	

Secretary

Chairman

Motion: Senator Pipinich moved adoption of the amendments denoted
in Exhibit #8. There being 1 objection and 7 ayes the motion carried.

ROLL CALL VOTE

SENATE COMMITTEE PUBLIC HEALTH, WELFARE & SAFETY

Date March 20, 1991 H Bill No. 620 Time 5:00 p.m.

NAME	YES	NO
SENATOR BURNETT		X
SENATOR FRANKLIN	X	
SENATOR HAGER		X
SENATOR JACOBSON	X	
SENATOR PIPINICH	X	
SENATOR RYE	X	
SENATOR TOWE	X	
SENATOR ECK	X	

Secretary

Chairman

Motion: Senator Franklin moved concurrence as amended.

There being 2 nays and 6 ayes the motion carried.

HOUSE BILL NO. 620

INTRODUCED BY SQUIRES, WEEDING

A BILL FOR AN ACT ENTITLED: "AN ACT REGULATING THE PRACTICE OF RESPIRATORY CARE; ESTABLISHING A QUASI-JUDICIAL BOARD OF RESPIRATORY CARE PRACTITIONERS WITH RULEMAKING AUTHORITY; REQUIRING LICENSURE OR A TEMPORARY PERMIT FOR RESPIRATORY CARE PRACTITIONERS; REQUIRING FEES FOR A TEMPORARY PERMIT AND A LICENSE; PROVIDING THAT THE FEES ARE DEPOSITED TO THE SPECIAL REVENUE FUND FOR THE BOARD'S USE; PROVIDING PENALTIES; REQUIRING PRACTITIONERS TO REPORT CERTAIN CONDUCT AND PROVIDING IMMUNITY FOR REPORTING; AND PROVIDING EFFECTIVE DATES."

STATEMENT OF INTENT

A statement of intent is required for this bill because [section 5] grants rulemaking authority to the board of respiratory care practitioners.

(1) In outlining the powers and responsibilities of the board of respiratory care practitioners, it is the intent of [section 5] that the board have authority to adopt rules to implement and enforce [sections 1, 2, and 4 through 13] and specific authority to adopt rules regarding:

(a) license and temporary permit applications and procedures necessary to receive and process those

applications;

(b) examinations and criteria for grading examinations;

(c) disciplinary standards for licensees and temporary permitholders, including definitions of conduct for which discipline may be appropriate;

(d) continuing education requirements;

(e) investigations of complaints;

(f) setting and modifying appropriate fees;

(g) a process for renewal of licenses and temporary permits, including procedures for late renewal;

(h) waiver of license requirements as provided in [section 7(2)]; and

(i) reciprocity conditions applicable to licensure.

(2) It is the intent of the legislature that the governor have the authority to implement staggered terms for board members during the appointment process.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Findings -- purpose.** The legislature finds and declares that the practice of respiratory care in the state affects the public health, safety, and welfare. To protect the public from the unqualified practice of respiratory care or unprofessional conduct by qualified practitioners, respiratory care is subject to regulation and control. The purpose of [sections

1 1, 2, and 4 through 13] is to regulate the practice of
2 respiratory care. The legislature recognizes that the
3 practice of respiratory care is a dynamic and changing art
4 and science that is continually evolving to include new
5 ideas and more sophisticated techniques in patient care.

6 NEW SECTION. Section 2. Definitions. As used in
7 [sections 1, 2, and 4 through 13], the following definitions
8 apply:

9 (1) "Board" means the board of respiratory care
10 practitioners established in [section 3].

11 (2) "Qualified medical direction" means the direction
12 of:

13 (a) a medical director of an inpatient or outpatient
14 respiratory care service, a respiratory care department, or
15 a home-care agency; or

16 (b) a licensed physician with a special interest and
17 knowledge about the diagnosis and treatment of respiratory
18 problems.

19 (3) (a) "Respiratory care" means the care provided by a
20 member of the allied health profession responsible for the
21 treatment, management, diagnostic testing, and control of
22 patients with deficiencies and abnormalities associated with
23 the cardiopulmonary system. The term includes but is not
24 limited to:

25 (i) administration of pharmacological, diagnostic, and

1 therapeutic agents related to respiratory care procedures
2 that are necessary to implement a treatment, disease
3 prevention, pulmonary rehabilitative, or diagnostic regimen
4 prescribed by a physician;

5 (ii) transcription and implementation of the written or
6 verbal orders of a physician regarding the practice of
7 respiratory care;

8 (iii) observation and monitoring of a patient's signs
9 and symptoms, general behavior, and physical response to
10 respiratory care treatment and diagnostic testing, including
11 determination of abnormal characteristics;

12 (iv) implementation of respiratory care protocols
13 pursuant to a prescription by a physician; and

14 (v) initiation of emergency procedures prescribed by
15 board rules.

16 (b) Respiratory care is not limited to a hospital
17 setting but must be performed pursuant to a physician's
18 order and under qualified medical direction. The term
19 includes inhalation and respiratory therapy.

20 (4) "Respiratory care practitioner" means a person who
21 has the knowledge and skill necessary to administer
22 respiratory care and who is licensed under the provisions of
23 [sections 6 through 10].

24 (5) "Student respiratory care practitioner" means a
25 person:

1 (a) enrolled in a respiratory care educational program
2 recognized by the joint review committee for respiratory
3 therapy education and the American medical association's
4 committee on allied health education and accreditation, or
5 their successors;

6 (b) permitted to provide respiratory care under
7 clinical supervision; and

8 (c) identified as a student respiratory care
9 practitioner or "SRCP".

10 NEW SECTION. Section 3. Board of respiratory care
11 practitioners. (1) There is a board of respiratory care
12 practitioners. The board consists of five members appointed
13 by the governor. Each member must be a citizen of the United
14 States and a resident of this state. The governor may
15 request advice from the Montana society for respiratory care
16 in making appointments to the board.

17 (2) The board consists of:

18 (a) three respiratory care practitioners, each of whom
19 has engaged in the practice of respiratory care for a period
20 of at least 3 years immediately preceding their appointment
21 to the board. At least one of these members must have passed
22 the registry examination for respiratory therapists
23 administered by the national board for respiratory care and
24 at least one of these members must have passed the
25 entry-level examination for respiratory therapy technicians

1 administered by the national board for respiratory care.

2 (b) one physician licensed in Montana who has a special
3 interest in the treatment of cardiopulmonary diseases; and

4 (c) one member of the public who is not a member of a
5 health care profession.

6 (3) The board is a quasi-judicial board, EXCEPT THAT
7 ONE MEMBER OF THE BOARD NEED NOT BE AN ATTORNEY LICENSED TO
8 PRACTICE LAW IN THIS STATE. Members are appointed, serve,
9 are compensated, and are subject to removal as provided in
10 2-15-124.

11 (4) The board is allocated to the department of
12 commerce for administrative purposes only as provided in
13 2-15-121.

14 NEW SECTION. Section 4. Board meetings -- procedure --
15 seal. (1) The board shall meet at least once a year and
16 shall elect annually a president, vice president, and
17 secretary-treasurer from its membership. The board may
18 convene at the request of the president or at other times
19 the board determines necessary to transact its business.

20 (2) The board shall adopt a seal by which the board may
21 authenticate its documents.

22 NEW SECTION. Section 5. Board powers and duties. (1)
23 The board shall:

24 (a) examine, license, grant temporary permits, and
25 renew the licenses or permits of duly qualified applicants;

(b) establish examinations and passing scores for licensure under [section 7];

(c) adopt and implement rules for continuing education requirements to ensure the quality of respiratory care.

(2) The board may:

(a) adopt rules necessary to implement the provisions of [sections 1, 2 and 4 through 13]; and

(b) establish relicensing requirements and procedures that the board considers appropriate.

NEW SECTION. Section 6. License required -- exceptions
 -- respiratory care not the practice of medicine. (1) Except as otherwise provided in [sections 1, 2, and 4 through 13], a person may not practice respiratory care or represent himself to be a respiratory care practitioner unless he is licensed or granted a temporary permit under the provisions of [sections 6 through 9].

(2) [Sections 1, 2, and 4 through 13] do not prohibit:

(a) the practice of respiratory care that is an integral part of study by a student respiratory care practitioner;

(b) self-care by a patient or the gratuitous care by a friend or family member who does not hold himself out to be a respiratory care practitioner; or

(c) respiratory care rendered in the course of an emergency.

(3) Nothing in [sections 1, 2, and 4 through 13] is intended to limit, preclude, or interfere with the practice of other persons and health care providers licensed by the appropriate agencies of the state of Montana.

(4) Nothing in [sections 1, 2, and 4 through 13] may be construed to permit the practice of medicine.

NEW SECTION. Section 7. Licensing requirements -- examination -- fees. (1) To be eligible for licensure by the board as a respiratory care practitioner, the applicant shall:

(a) submit to the board an application fee in an amount established by the board and a written application on a form provided by the board demonstrating that the applicant has completed:

(i) high school or the equivalent; and

(ii) a respiratory care educational program accredited or provisionally accredited by the American medical association's committee on allied health education and accreditation in collaboration with the joint review committee for respiratory therapy education or their successor organizations; and

(b) pass an examination prescribed by the board, unless the examination requirement is waived under subsection (2). The board may use the entry-level examination written by the national board for respiratory care or another examination

that satisfies the standards of the national commission for health certifying agencies or the commission's equivalent.

(2) The board may issue a license to practice respiratory care to an applicant without requiring him to pass an examination if the applicant:

(a) is currently licensed to practice respiratory care under the laws of another state, territory, or country if the board considers the qualifications for licensure to be equivalent to those required in this state; or

(b) holds credentials, conferred by the national board for respiratory care, as a certified respiratory therapy technician or a registered respiratory therapist and affirms under oath that his credentials have not been suspended or revoked.

(3) A person holding a license to practice respiratory care in this state may use the title "respiratory care practitioner" and the abbreviation "RCP".

NEW SECTION. Section 8. Renewal of license -- application and fee. (1) A respiratory care practitioner's license expires 1 year from the date of issuance.

(2) A licensee may renew his license by:

(a) filing an application with the board on a form approved by the board;

(b) paying a renewal fee in an amount established by the board; and

(c) documenting that he has completed the continuing education requirements prescribed by the board.

(3) An application for renewal of a license made within 90 days after expiration of the license is timely, and the rights and privileges of the applicant remain in effect during that period.

NEW SECTION. Section 9. Temporary permit. (1) The board may issue a temporary permit to practice respiratory care for a period of 1 year, pending receipt of an application for licensure and upon payment of a temporary permit fee in an amount established by the board. To receive the permit, the applicant shall demonstrate in writing, confirmed by oath, that he:

(a) has applied for licensure by reciprocity pursuant to [section 7(2)]. If the board considers the application and denies it, the temporary permit shall lapse.

(b) has taken the examination for licensure and is awaiting the results; or

(c) is a student respiratory care practitioner who expects to graduate within 30 calendar days of his application.

(2) Upon expiration of the permit and payment of an additional fee in an amount established by the board, the board may issue a permit for an additional period not to exceed 1 year pending reexamination or compliance with the

1 provisions of [section 7].

2 (3) An applicant who reapplies for a temporary permit
3 after he has abandoned a previous application is not
4 entitled to a permit.

5 NEW SECTION. **Section 10.** Revocation, suspension, or
6 refusal to renew license. The board may, after notice and
7 hearing, revoke, suspend, or refuse to issue a license or
8 permit; refuse to renew a license to practice respiratory
9 care; or take other appropriate disciplinary action if the
10 board finds that an applicant or respiratory care
11 practitioner:

12 (1) is guilty of fraud or material misrepresentation in
13 obtaining or attempting to obtain a license or renew a
14 license to practice respiratory care;

15 (2) is guilty of gross negligence, incompetency, or
16 misconduct in the practice of respiratory care;

17 (3) is habitually intemperate in the use of narcotic
18 drugs, alcohol, or any other drug or substance that impairs
19 the user physically or mentally;

20 (4) has obtained, possessed, used, or distributed
21 illegal drugs or narcotics;

22 (5) is guilty of unprofessional conduct as defined by
23 the board or is guilty of moral turpitude;

24 (6) has practiced respiratory care after his license or
25 permit has expired or been suspended or revoked;

1 (7) has practiced respiratory care under cover of any
2 permit or license illegally or fraudulently obtained or
3 issued; or

4 (8) has aided or abetted others in the violation of any
5 provision of this section or the rules adopted under this
6 section.

7 NEW SECTION. **Section 11.** Duty to report violations --
8 immunity from liability. (1) Notwithstanding any provision
9 of state law regarding the confidentiality of health care
10 information, a respiratory care practitioner shall report to
11 the board any information that appears to show that another
12 respiratory care practitioner is:

13 (a) mentally or physically unable to engage safely in
14 the practice of respiratory care; or

15 (b) guilty of any act, omission, or condition that is
16 grounds for disciplinary action under [section 10].

17 (2) There is no liability on the part of a respiratory
18 care practitioner and no cause of action may arise against a
19 respiratory care practitioner who in good faith provides
20 information to the board as required by subsection (1).

21 NEW SECTION. **Section 12.** Penalty. A person convicted
22 of violating any provision of [sections 1, 2, and 4 through
23 13] is guilty of a misdemeanor and shall be fined an amount
24 not to exceed \$500, or shall be imprisoned in a county jail
25 for a term not to exceed 6 months, or both.

1 NEW SECTION. **Section 13.** Deposit of fees. All fees and
 2 money received by the department must be deposited in the
 3 state special revenue fund for the board's use subject to
 4 37-1-101(6).

5 NEW SECTION. **Section 14.** Licensure -- grandfather
 6 provision. The board shall grant a license to practice
 7 respiratory care without examination or completion of the
 8 requisite educational program to a person who has been
 9 performing respiratory care in this state for at least 1
 10 year on [the effective date of this section].

11 NEW SECTION. **Section 15.** Severability. If a part of
 12 [this act] is invalid, all valid parts that are severable
 13 from the invalid part remain in effect. If a part of [this
 14 act] is invalid in one or more of its applications, the part
 15 remains in effect in all valid applications that are
 16 severable from the invalid applications.

17 NEW SECTION. **Section 16.** Codification instruction. (1)
 18 [Section 3] is intended to be codified as an integral part
 19 of Title 2, chapter 15, part 18, and the provisions of Title
 20 2, chapter 15, part 18, apply to [section 3].

21 (2) [Sections 1, 2, and 4 through 13] are intended to
 22 be codified as an integral part of Title 37 and the
 23 provisions of Title 37 apply to [sections 1, 2, and 4
 24 through 13].

25 NEW SECTION. **Section 17.** Effective dates. [Sections 3

1 through 5, 14 through 16, and this section] are effective on
 2 passage and approval.

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